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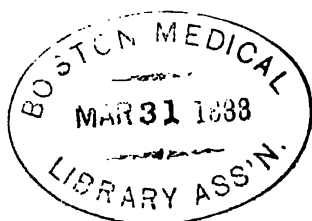
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THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS
OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.



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THE MEDICAL ANALECTIC

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R. W. AMIDON, M.D.

VOL. IV., No. I.

January, 1887.

WHOLE No. 37.

LEADING ARTICLES.

On the Therapeutic Utility of Gaseous Enemata.—In a preliminary note¹ attention was called to this new method as practised by its inventor, Bergeon.² At that time he had employed the method only in pulmonary phthisis, making use of sulphurous mineral water. In a later communication³ he advocates its use in other disorders of the respiratory tract. Having to care for many phthisical patients, many of whom have laryngeal phthisis of various sorts, he has been struck by the poor results of local treatment of the same, aside from the very disagreeable and often painful nature of local applications. Such local treatment he has abandoned and has substituted gaseous enemata, by which means he claims that he always secures cessation of pain, relief of spasm, and finally complete cicatrizations of ulcers. He cites a typical case⁴ as follows: This patient had sought treatment ten months before for an aphonia due to destruction of the vocal cords; the patient at the time was in the last stages of hereditary consumption. The pains in the throat were so violent that the patient ate nothing for three days, to avoid the agony caused by movements of deglutition. A few days' treatment by gaseous enemata relieved the pains, and in two or three weeks the ulcers commenced to heal. Cicatrization had been maintained eight months, in spite of the state of the lungs, which were the seat of large excavations.

In acute phthisis, phthisis of pneumonic origin, and galloping tubercular phthisis, where the prognosis is generally so grave,

Bergeon asserts that gaseous enemata produce a rapid lowering of the temperature, a slowing of the pulse, a checking of sweats, cough, and expectoration to such an extent that patients may often be called convalescent in from fifteen to twenty days.

Cornil,⁵ in an article on the same subject, explains a simple way of generating and using the gas. Carbonic acid gas is generated in a strong flask by the action of dilute sulphuric acid on bicarbonate of soda, whence it is conducted into a gas-holder of any sort capable of storing several litres of the gas. From this receptacle it can at any time be passed by means of tubes through sulphurous or any medicated water, and then by other tubes be introduced into the bowels of the patient. Cornil thinks the crucial test of the method is by thus treating animals rendered tuberculous, and says he has many such experiments already started.

Chantemesse⁶ has had some favorable results with this treatment in his hospital service during September and October. According to him asthmatic attacks are cured by enemata of CO₂ charged with sulpho-carbonaceous vapors. He treated nine patients with general and local signs of pulmonary tuberculosis and bacilli in the sputa, with great amelioration of symptoms. The weight of the body increased rapidly, while the cough and expectoration markedly diminished. The bacilli continued to be present in the sputa. One of these patients gained nine pounds in a month and a half.

De la Roche⁷ has experimented with and elaborated Bergeon's method. The first results of the treatment he expects to see are a lowering of temperature, the return of natural sleep, the cessation of

¹ THE MEDICAL ANALECTIC, Sept., 1886, p. 431.

² *Gas. des. Hôp.*, Aug. 17, 1886.

³ *La France Méd.*, Nov. 13, 1886.

⁴ The patient was presented for examination by members.

⁵ *La France Méd.*, Nov. 13, 1886.

⁶ *La France Méd.*, Nov. 13, 1886.

⁷ *Lyon Médical*, Nov. 28, 1886.

night-sweats, and the diminution of purulent expectoration. The appetite improves, the strength returns, and the body-weight increases. These phenomena follow a checking of suppuration and septicæmia. In some cases also it checked a diarrhoea which was present, while in others it seemed to cause a constipation, which had to be overcome by laxatives. The treatment in some cases produces colicky pains, which in one instance were so severe as to necessitate a cessation of treatment. This patient had advanced hemorrhoidal trouble and fissure of the anus. De la Roche has in some cases replaced the sulphurous water by the essence of eucalyptus. By varying the medicinal substances he believes the method of Bergeon applicable to numerous affections, whether of parasitic (microbic) or nervous origin. He does not think all tuberculous subjects should be treated this way. Where both lungs are extensively invaded and much dyspnoea is present, he considers the treatment unwarrantable.

Reid (J.) on Drumine — A New Australian Local Anæsthetic. — Dr. Schomburg of the Adelaide Botanical Gardens determined the species and order to be *Euphorbia Drummondii*, N.O. *Euphorbiaceæ*. He uses the hydrochlorate of the alkaloid which he calls drumine, which is very soluble in water, and calls it drumini chloridum. Crystals deposited from the hydrochloric solution are circular or boat-shaped at the circumference, and stellate, or perhaps more correctly, discs, as if formed of concentric circles, and with radiating or other fissures. They are colorless, and under high power of the microscope, the acicular crystals are in some cases rhomboid in shape. Dr. Schomburg asserts that a great many sheep and cattle are annually killed by the plant, which is more poisonous according to the quantity of milky juice it contains. From farmers it is learned that sheep, bullocks, and horses die in from twenty-four hours to seven days after eating it, all presenting paralyzed extremities, some hang the head as if tipsy, while appetite does not seem to be impaired. At first the weed is avoided and eaten only on account of extreme hunger, but afterwards it is sought after and eaten with great avidity. One gentleman has seen yellow eyes occurring with some jaundice.

The author has experimented as much

as the limited amount of the drug at his disposal would permit. On cats he finds that it acts very speedily as a local anæsthetic, whether injected hypodermically or applied to the mucous membranes of the eye, nose, throat, etc. When given in large doses (gr. xx.), added to the local effect, there are general symptoms of a narcotic nature. The animal tolerates blows and does not resent handling, hangs head as if inebriated, has a stupid stare, shows no desire for food or drink, evacuates bladder when it is full, rarely evacuates bowels (probably because eats nothing). The breathing after large doses is slow and difficult. The seeming paresis of the extremities after large doses the author thinks more likely due to sensory than motor paralysis. In no case did convulsions follow the use of the drug. Introduced into the eye it produces speedy anæsthesia of the cornea and conjunctiva, does not affect the pupil or fundus oculi. It causes some lachrymation but no inflammation. Strychnia has very little if any antagonistic effect, but the author thinks that the drug (drumine) fortifies animals against chloroform. The post-mortem appearances are not significant.

The author found that on himself, when locally applied, it abolished general sensation and the sense of taste from the side of the tongue to which it was applied.

He has made a few therapeutical trials of the drug. He records the permanent relief of a chronic sciatica by the hypodermic injection of gr. $\frac{1}{2}$, on two successive days. In facial neuralgia he has used it locally, and introduced it into the eye with success.

He recommends a trial of it in painful nervous affections; in hydrophobia and croup, where it could be applied to the nostril by a fine spray or introduced into the larynx by means of a fine hypodermic needle; as an adjuvant to intrapulmonary injections; in painful peritoneal and bowel ailments; and in writer's cramp and similar affections. He considers it more useful than cocaine; first, because the latter drug is much adulterated, and secondly, because drumine seems to have a more purely sensory action than cocaine and causes no excitement. — *Australasian Med. Gaz.*, Oct., 1886.

Suckling (C.W.) on the Diagnosis of Uræmia from Apoplexy. — Chantemesse and Tenneson, in the *Revue de Médecine*, November, 1885, relate cases of partial

epilepsy and hemiplegia in Bright's disease which they have, by post-mortem examination, proved to be due to local oedemas of the brain.

I believe that it is not generally known that hemiplegia occurs in uræmia, thus occasionally making the diagnosis between uræmia and apoplexy an extremely difficult one. As in uræmia the treatment must be one of active interference, while in apoplexy the opposite holds good, the diagnosis is of the utmost importance.

I have recently met with two cases similar to those reported by Chantemesse and Tenneson. A man aged forty was recently admitted into the workhouse infirmary in a comatose condition, with right hemiplegia and without convulsions. The pulse was of high tension, the heart considerably hypertrophied, and there was a trace of albumen in the urine.

All these symptoms were compatible with the diagnosis of cerebral hemorrhage. To my astonishment he recovered consciousness immediately after being bled, the hemiplegia passing off in a few hours.

During his stay in the infirmary he had five other attacks, which were always preceded by delirium and restlessness, together with violent convulsion of the right side of the face, right arm and leg, and conjugate deviation of the eyes to the right, giving place to hemiplegia, the eyes then being turned to the left. Each attack was cured by a small bleeding. The urine in this case was free for days from albumen, though it was tested at various periods of the day.

The other case was that of a woman aged sixty-two, brought in one evening completely comatose. There was right hemiplegia, conjugate deviation of the eyes to the left, dilatation of the right pupil, and abolition of the right conjunctival reflex.

The breathing was of the "Cheyne-Stokes" type, the heart a little enlarged, but the pulse of low tension. Clonic spasm of the facial muscles occurring at short intervals, the case was suspected to be uræmic, though the urine apparently was not albuminous, and I ordered her to be bled. One ounce and a quarter were drawn, and she became conscious almost immediately after.

The next day the hemiplegia had disappeared, but she had sensory aphasia, there being "word blindness" and "word deafness." Free purgation was kept up, and within two days she was perfectly well.

On testing the urine by daylight I found there was a slight trace of albumen present, the quantity of urea being only 1 per cent., and the average daily quantity of urine passed being forty ounces. I could discover no casts, and there was no change in the fundus oculi.

In both the above cases the temperature was a little below normal; and in both no history of the onset of the attack could be obtained, the patients being brought in from the street by the police. In the diagnosis of these cases the occurrence of convulsions is of great assistance. A convulsion occasionally occurs at the onset of apoplexy, but is rarely repeated, while in uræmia convulsions are common, and usually frequently repeated; any elevation of temperature would be strongly in favor of apoplexy. In all cases, when in doubt between apoplexy and uræmia, I should bleed.—*Brit. Med. Jour.*, Dec. 4, 1886.

Brown - Séquard on Cadaveric Rigidity.—The author at the end of two communications made to the Académie des Sciences draws the following conclusion: That while the coagulation of albuminous substances may be the principal cause of cadaveric rigidity, and is sometimes the only cause, still the state of the muscles very much resembles that of a true contracture, a vital condition, though present in corpses. From studies of his own and of others, he considers it proven, that a stoppage of circulation can cause contractures; that, aside from nervous action, a contracture may persist, the circulation continuing; that after death, contracture has been known to appear and disappear many times, independent of any action of the nervous centres. He says: "I have often found, even several days after death, that if I stretch and soften rigid muscles, they not only contract again, but become stiffer than they were before the manipulation, which implies that the mechanical excitation to which they were subjected threw them into a state of contracture, as it would during life; and I have also satisfied myself that, in muscles vigorously contracted, either during life or after death, no stimulation excites contraction."

He proposes to show in a future communication that the nervous system exerts an immense influence in precipitating or retarding cadaveric rigidity.—*L'Union Méd.*, Oct. 30 and Nov. 6, 1886.

THERAPEUTICS.

Steele (J. G.) on Garrya Leaves.—

The California fever bush is found on the highest elevations of the coast range of mountains of California. It presents a most striking feature in the landscape, resembling at a distance, a gorgeous, green velvet mantle, loosely laid on the mountain tops, and aggregating here and there into folds. The botanical name of the plant is *Garrya Fremontii*—order, *Cornaceæ*,—and it is a shrub 5 to 10 feet high, becoming glabrous; leaves ovate to oblong, not undulate, $1\frac{1}{2}$ to $2\frac{1}{2}$ inches long, acute at each end, on petioles 4 to 6 inches long, with acute somewhat silky bracts.

The garrya leaves have been known as an antidote to chills and fevers since the occupation of the State by the Americans. The leaves, which are the parts of the plant used in medicine, when chewed excite a profuse flow of saliva, which becomes deeply tinged with the green coloring matter of the leaves. They also impart a deep (almost nauseous) and persistent bitter taste, resembling the after-taste of a good specimen of chinchona bark. The leaves, when chewed for a while, also excite a sense of warmth in the mouth. When swallowed, the fluid extract usually excites a sense of warmth in the epigastrium, which often diffuses itself over the abdomen, attended sometimes, particularly in overdoses, with gastric and intestinal irritation. It stimulates the circulation, and all the functions seem to be moderately excited. Its action on the nervous system is sometimes evinced by a sense of tension or fulness, a slight pain in the head, ringing in the ears, and with some temporary deafness, which effect, on the interruption of the remedy, promptly subsides, leaving no disagreeable after-effect to torment the patient; administered between the paroxysms of intermittent disorders, it interrupts and checks the progress of the disease, which well-known effect has caused it to be entitled "*The California fever bush*." It can also be employed with benefit in morbid conditions of the system, whatever may be the peculiar modifications in which a convalescent effect is desired. In low or typhoid forms of disease, the garrya leaves are of great advantage in supporting the system, till the malarial action cease. It has thus been given with benefit in the latter stages of typhus fever; in scarlatina, measles, etc.,

as a tonic; the garrya is also advantageously given in chronic diseases, connected with debility such as scrofula, hemorrhages, dyspepsia, amenorrhœa, etc.

In the treatment of intermittents, it seems to display extraordinary powers. No case of "fever and ague," so prevalent in California (as in many newly-settled countries), has been known to resist the curative effect of the leaves. The fluid extract, given judiciously, represents the medicinal virtues of the leaves, and is preferred to the more bulky and uncertain infusion or decoction. Diarrhœa and dysentery, which often put on the intermittent form, especially in miasmatic districts, are cured by the garrya. Remittent fever, when preceded by depleting measures, yields promptly to this remedial agent.

The dose of the fluid extract, made so that sixteen fluid ounces represent sixteen troy ounces of the leaves, is from ten to thirty drops, to be repeated or varied according to the disease and the effect intended to be produced.—*Pacif. Record of Med. and Phar.*, Nov. 15, 1886.

Kolipinski (L.) on Some of the Properties of Sodium Fluoride.—In animals the author has found this drug to act chiefly as a local irritant, and also in some way to induce asphyxia. It is quickly excreted by the urine, which may be albuminous. Two grains is a large but not fatal dose for a cat.

His clinical experiments on twenty-nine subjects induce him to believe that the drug has a curative effect on functional headaches, especially those dependent on gastric or bowel disturbances. He also considers its results in intermittent and remittent fever are encouraging. Three cases of epilepsy treated by him with the drug were much improved—the almost constant sequence of any new therapeutical departure.—*Four. Am. Med. Ass'n*, Aug. 21, 1886.

Bignon on the Antagonism between Strychnine and Cocaine.—In dogs given strychnine, gr. $\frac{1}{10}$ (.001) per pound (500.) by the mouth, life can be saved by the hypodermic administration of cocaine to the point of inducing the cerebral symptoms of the drug, provided the point of elimination be not passed. Recovery can ensue even after the first tetanic spasm takes place. After a dose of strychnine, gr. $\frac{1}{10}$ (.0015) per pound (500.), the cocaine will still for some hours counteract

the poison, but the animal dies nevertheless, killed by the cocaine which must pass the toxic limit—more than gr. $\frac{1}{8}$ (.001) per pound (500.)—*Bull. Gén. de Thé.*, Oct. 30, 1886.

Eccles (R. G.) on Drugs and Digestion.—The author has performed numerous elaborate experiments to determine the effect of various drugs and chemicals on the digestive process, which, in the present instance, is carried on artificially at a fixed temperature 100°–120° F. (40°–49° C.).

At first some acids were tried with the following results, the figures denoting the number of hours digestion was delayed, the minutes being omitted: Chromic, picric, molybdenic, sulphuric, thymic, hydrobromic, salicylic, pyrogallic, nitric, over 10 hours; hyperchloric, cathartinic, chrysophanic, and tannic acid, 3 hours; benzoic, oxalic, citric, tartaric, oleic, boric, acetic, and lactic, over 2 hours; and phosphoric, arsenious, and gallic, 2 hours. Of the alkaloids and their salts: Ferrocyanide of quinine, citrate of iron and strychnine, citrate of iron and quinine, delayed over 5 hours; sulphate of cinchonidine, sulphate of cinchonine, sulphate of quinidine, sulphate of quinine, bisulphate of quinine, sulphate of strychnine, 4 hours or over; tannate of quinine, salicylate of quinine, salicylate of cinchonidine, chloride of quinine, bromide of quinine, sulphate of atropine, 3 hours or over; hydrochloride of cocaine, chloride of morphine, bromide of caffeine, veratrine, strychnine, aconitine, brucine, morphine, acetate of strychnine, chloride of pilocarpine, acetate of morphine, codeine, 2 hours or over. Of essential oils: Cinnamon, pimento, lemon-grass, bitter-almond, retarded digestion over 10 hours; clove, over 9 hours; bay, bergamot, sassafras, over 8 hours; winter-green, 5 hours; rose and origanum, 4 hours; citronella, caraway, coriander, spearmint, pennyroyal, aniseed, fennel, lavender, peppermint, thyme, wormwood, erigeron, cajuput, rosemary, nutmeg, rose-geranium, orange, over 3 hours; lemon, wine (ethereal), amber, neroli (petale), black-pepper, juniper, savin, cedar, patchouli, croton, sandal-wood, cubeb, turpentine, over 2 hours. Of balsams: tolu retarded digestion, 5 hours; peru, 4 hours; canada and copaiba, over 2 hours. Of tinctures: those of the chloride of iron, iodine co., chloride of iron (tasteless), guaiaci, guaiaci ammon., lupulin, delayed digestion over 10 hours; belladonna, 9

hours; Warburg's cannabis indica, opium, 8 hours; benzoin co. and simple, 6 hours; verat. virid., cubeb, buchu, aloes and myrrh, valer. of ammon., hyoscyamus, over 5 hours; asafoetida, tolu, kino, myrrh, 4 hours; catechu, colchicum root, digitalis, physostigma, colocynth co., modified Warburg, avena sativa, santal., gentian co., sanguinaria, cinchona simp., nux vomica, cascarilla, senega, capsicum, hops, gentian, orange-peel, galls, senna, lobelia æther., krameria, quassia, valerian, aloes, colchicum seed, cinchona co., 3 hours; stramonium, cardam. simp., cardam. co., lobelia, squills, rhubarb co., cinnamon, ginger, cantharides, lavender, ipecac co., poke, rhubarb, aconite root, aconite leaf, lemon-peel (fresh), opium (camphorated), colombo, angustura, cochineal, virg. snake-root, conium, arnica, and dilute alcohol, 2 hours. Of some organic substances: beta naphthol, santonin, with alcohol and chloroform, caused a delay of 4 hours; menthol and nitrite of amyl, 3 hours; croton chloral, chloral hydrate, vanillin, antipyrine, concent. sulph. ether, powdered gum-arabic, sweet spirits of nitre, acetic ether, benzole, salicin, over 2 hours; and ethyl alcohol, methyl alcohol, peraldehyde, urea, milk sugar, cane sugar, glycerin, santonin without alcohol, just 2 hours. Of fluid extracts: digitalis, wild cherry, buchu, cascara sagrada, buckthorn, guarana, hyoscyamus and colchicum root, 3 hours; aconite, valerian, taraxacum, liquorice, gentian, ergot, 2 hours.

The sulphates are the most active inhibitors of digestion. Among the alkaloidal salts the same was the case. Why sulphate of quinine ever came to be so universally prescribed in preference to the much better chloride, is hard to tell. The same is true of sulphate of morphine. In the chlorides there is more of the active principle to the same weight, they are much more soluble in the gastric juice, and they retard digestion less. Next to the sulphates the nitrates are the great retarders. The bromides average lower than the chlorides, while the latter are about even with the iodides. Bromide of iron ranges high, like many of the iron non-organic salts. Dialysed iron and the solution of pernitate of iron retarded respectively 150 and 110 minutes when fifteen centigrammes were used, which is lower than the run of their class. The salicylates are far above the benzoates, and the chlorates hinder much more than the chlorides. The gen-

eral run of all agrees very well with the activity of their acids.

Antiseptics averaged high as retarders, and an approach is made by them in this power that runs nearly parallel with their germ-destroying power. Potassio-mercuric iodide, the most potent germicide known, was found to hold back digestion one hour when only one part in ten thousand was used. Bichloride of mercury required but one part in five thousand to retard fifteen minutes. While there are substances not known to be germicides that retard still more, still it is somewhat curious to find this class range so high, and at the same time occupying positions toward each other that suggest the order of their germ-destroying power. The molybdates seem to lead every thing else as inhibitors, and they are the very best known precipitants of peptone.—*N. Y. Med. Jour.*, Dec. 11, 1886.

Bedoin on a New Use of Gelosine.

—Attention has already been called¹ to the extraordinary expansile property of gelosine when moistened. Bedoin has employed bougies of gelosine to produce gradual dilatation of urethral strictures. In these bougies he has incorporated boric acid and cocaine and suggests the use of bougies having sublimate, iodoform, and other medicaments. Simply moistened they are easily introduced and, by gradually and painlessly absorbing the urethral moisture, slowly dilate the stricture.—*Bull. et Mém. de la Soc. de Thérap.*, Dec. 15, 1886.

Castellan (A.) on the Treatment of Acute Gonorrhœa by Alkaline Injections.—The author, noticing in what a large percentage of cases of acute gonorrhœa the discharge is strongly acid, tests the discharge with litmus paper and if it is acid orders injections of a solution of bicarbonate of soda $\frac{1}{10}$ to 1 % in water, three or four times a day until the discharge becomes bland. Seven or eight days generally suffices to change the character of the discharge, which then gradually disappears. As a general thing this treatment relieves the painful micturition. If it does not a little opiate is also employed.—*Bull. gén. de Thérap.*, Dec. 15, 1886.

Stuver (E.) on Fluid Extract of Corn Silk (Stigmata Maidis) in the Primary or Acute Stage of Gonorrhœa.

—I began using corn silk in irritating and painful affections of the kidneys and bladder, attended by dysuria, about five years ago, and in the *Medical News* of Oct. 6, 1883, published an article on its "Anæsthetic and Diuretic Effects." In this article special attention was called to the beneficent influence it exerts over the irritable condition, attended by frequent micturition, so often encountered in pregnancy.

Encouraged by the results obtained in the above-mentioned class of cases, I decided to test its merits in allaying the irritation and pain in the acute stage of gonorrhœa.

C. H., laborer; contracted gonorrhœa a short time ago; discharge made its appearance yesterday; inflammatory action high, and pain on micturition severe. After giving the ordinary directions as to the regulation of diet and the alvine evacuations, abstention from spirits, etc., I gave the following, viz.:

R Potassi acetatis 3 iii.
Fl. ext. stigmatæ maidis,
Aque destillatæ, aa ad q. s. f 3 iv. M.
SIG.—3 ii in water every two hours.

The following day he reported himself as greatly relieved, and under this treatment not only did the irritation and pain subside in three days, but the discharge almost entirely disappeared.—*Therapeutic Gaz.*, Dec. 15, 1886.

Barnett (J. R.) on the Salicylate of Ammonia in the Treatment of Typhoid and Septic Fevers and Inflammations.—The salicylate of ammonia is to be ranked among the most efficient of the antipyretics.

As an antipyretic in all fevers characterized by extreme adynamia it ranks among the safest, owing to its ammonium base.

It is stimulant as well as antipyretic, and thus of itself fulfils indications otherwise only met by a combination of remedies.

It is an agent of wide germicidal powers, being promptly efficient in affections of great etiological and pathological differences, each confessedly arising from its own proper specific infecting micro-organism.

As a remedial agent in typhoid and remittent fevers it is unsurpassed, aborting them at the outset, under favorable conditions, and greatly mitigating their severity and danger under circumstances less favorable.

It is entitled to confidence in the treat-

¹ THE MEDICAL ANALECTIC, 1886, p. 298.

ment of pulmonary inflammations, either idiopathic or septic, and probably eliminates the dangerous factor, embolism, with greater certainty than any other prime curative agent.

It is the most efficient known remedy in puerperal septicæmia and probably also in most septic inflammations of non-puerperal origin.

It is worthy of a trial in non-tubercular cerebral meningitis, as it gives some promise of relief in an affection which has hitherto resisted, if not resented all modes of medical treatment.

Some twenty-five or more cases of typhoid or allied fevers have been under my care during the present autumn.

With one exception they were subjected to the salicylate of ammonia treatment only, and uniformly without alcoholic stimulation, and with the exception noted they all recovered. Of these cases all were convalescing by the close of the second week. Three showed entire absence of fever on the twelfth day, three more on the ninth; all the rest were convalescent at the end of the first week or earlier.

The case in which the ammonium treatment was not strictly adhered to died on the ninth day of the fever, two days after the occurrence of an enormous nasal hemorrhage.

A drachm of the medicine is generally given within a few hours in divided doses. Structural changes in the kidneys seem to constitute a contra-indication for the drug.

—*Four. Am. Med. Ass'n*, Dec. 11, 1886.

Brookes (H. S.) on an Elegant Seidlitz-Powder Solution.

SOLUTION NO. 1.

- ℞ Sodii bicarbonatis ʒij.
Potassii et sodii tart. ʒij.
Syr. aurantii cort. recent. ʒvi.
Aq. gaultheriæ ad. ʒij.
M. ft. sol.

SIG.—Pour in a goblet half full of cracked ice.

SOLUTION NO. 2.

- ℞ Acid tartarici. gr. xxxv.
Syr. aurant cort. recent. ʒss.
Aq. gaultheriæ ad. ʒj.
M. ft. sol.

SIG.—Add to No. 1 and drink while effervescing.

This forms an agreeable and effective aperient, devoid of any saline taste, effervescing slowly, and contains the virtue of one seidlitz powder, U. S. P., 1880.

This may be prescribed in quantity, as it will keep indefinitely.

The taste is as agreeable as soda water.

Aromatic syrup may be used if it is desired.—*St. Louis Courier of Medicine*, Dec., 1886.

Anderson (E.) on Bitartrate of Potash in Pregnancy.—My experience has been that if the bitartrate of potash be administered to a pregnant woman for one month prior to confinement, in a sufficient amount to bring about free action of the kidneys and bowels, puerperal convulsions will never occur. In my opinion, opium should never be given where eclampsia is threatened, unless its use be preceded by free purgation or venesection, as it will be very apt to cause what we wish to prevent.—*Maryland Med. Jour.*, Dec. 25, 1886.

Frontis (D. B.) on Antipyrine and Arsenic in the Treatment of Malarial Fevers.—Physicians who practise in malarious districts not rarely meet with a class of patients suffering from malarial fever in some of its forms, who from idiosyncrasy or from some complication of the case cannot take quinine or any derivative of cinchona bark.

The author has met with cases manifesting this peculiarity in intermittent, remittent, and a more indistinct type, generally classed here as simple malarial fever. Having during the past twelve months used the new antipyretic—antipyrine—with most gratifying results in phthisis, he determined to try it in this class of malarial troubles, using it to control the pyrexia, and putting the patient on full doses of arsenic to counteract the malaria.

His method is to give antipyrine in gr. xv. doses or more once or twice a day and gtt. v. doses of Fowler's solution t. i. d., adding in some cases moderate amounts of quinine.—*Med. News*, Dec. 11, 1886.

Keown (S. L.) on Strychnia Hypodermically in Malarial Hæmaturia.

The writer uses $\frac{1}{30}$, $\frac{1}{20}$, or $\frac{1}{10}$ gr. of strychnia hypodermically, if necessary. He says, "Strychnia standing at the head of vaso-motor stimulants, produces contraction of the relaxed blood vessels, upon which the leakage depends in malarial hæmaturia, etc.; hypodermic administration is greatly to be preferred in such cases, on account of the extreme irritability of the stomach, and to secure immediate action." He does not use this to the exclusion of quinine, but finds the latter insufficient without it.—*Daniel's Texas Med. Jour.*, Nov., 1886.

Dehenne on the Hypodermic Use of Ergotine in Diabetes.—The author

has followed this method in thirty cases and has never seen it fail to diminish the amount of sugar in the urine. One of his cases, a woman of sixty-eight, had had a double cataract for two years. She passed five or six quarts of urine a day, and it contained two and a half ounces of sugar to the quart. Subcutaneous injections of ergot were practised for fifteen days. On the eighth day the sugar was reduced to one half ounce per quart. On the fifteenth day the patient read the newspaper. Treatment was suspended for a month, when the sugar increased to over an ounce per quart. On commencing the injections again the sugar fell to three drachms per quart. This patient would never consent to diet.—*L'Union Méd.*, Nov. 13, 1886.

Chéron (J.) on Camphorated Bisulphide of Carbon in the Treatment of Lumbo-Abdominal Neuralgia.

The writer employs a saturated solution of camphor in the bisulphide of carbon. It is applied to the painful point for three or four minutes by means of a brush. The skin becomes white as the camphor is left in a fine adherent powder on the evaporation of the solvent. It produces first a sensation of intense cold followed by a burning. It produces a marked local anæsthesia. The writer has found it particularly useful in neuralgias of the lumbo-abdominal type, painting the skin covering the lumbar spine, the sacrum, and the points of emergence of the small sciatic nerves.—*Rev. de Thérap.*, Dec. 1, 1886.

Cimicifuga in Chorea.—Dr. D. Colvin, of Clyde, N. Y., corroborates, by a thirty-years' experience, the very great utility of cimicifuga in chorea, as recently advocated by Dr. H. Corson.¹ He also finds it very useful in rheumatism and the nervous irritability of phthisical patients. Dr. Colvin gives it daily in the last month of pregnancy, when he has reason to suppose that labor will be tedious, and with the best results.—*Med. and Surg. Reporter*, Dec. 1, 1886.

Love (J. N.) on Vaginal Alimentation.—The author says: "In many cases vaginal feeding, stimulation, and medication is beneficial; in many others it is a potent means for saving and prolonging life.

"Whether the vagina or rectum be used for purposes of feeding, the materials

should be as thoroughly digested previous to using as is possible; the milk, albumen, or beef fibre completely peptonized and the starchy matters changed into dextrose or glucose."

After the introduction of the food or medicament, he usually places over the vaginal opening a small mass of absorbent cotton covered with oil silk, and held in position by a T-bandage.—*New Eng. Med. Monthly*, Nov. 15, 1886.

Stockman (R.) on the Action and Therapeutical Value of Vegetable Astringents.

—Either when locally applied, or after absorption into the blood, gallic acid evidently exercises no other action than that of a weak inorganic acid, and certainly has no claim to any special action as an astringent. The only action which it can have in this direction, is the power which it possesses, in common with all other acids, of diminishing the alkalinity of the blood, and thereby increasing its tendency to coagulate. Stronger acids, however, will act much more powerfully in this direction than it does. Any influence in lessening the calibre of the blood-vessels, either by peripheral or central action, must be denied to it. When locally applied, the fact that it does not precipitate albumen must prevent it having any influence on a catarrhal inflammation.

As regards tannic acid, the matter is somewhat more complicated. Locally applied, its action for good depends on its power of precipitating albumen, the layer of tannate of albumen which is formed acting as a protective to the underlying mucous membrane. To this action is due its value in catarrhal inflammations of the alimentary canal, and in discharging surfaces generally.

Its usefulness is limited to such cases, and that as a remote astringent it is valueless. In weak solution, and uncombined, its action on contractile tissues, such as the vascular walls, is simply that of a dilute acid, while it is only when stronger solutions are used (much stronger than can ever exist in the blood, even if it were not in combination there) that its power of precipitating albumen comes into play. When its chemical affinities have been satisfied by neutralizing it with a base or with albumen, it is no longer capable of precipitating albumen, and exercises, therefore, little or no influence on the parts with which it comes in contact.

¹ See MEDICAL ANALECTIC, Dec., 1886, p. 535.

Independently of these considerations, the very small quantity in which it exists at any one time in the blood, and that in combination, must also militate against its having any remote action. As we have seen, the only channels of excretion besides the bowel are the kidneys, and hence it is hardly possible that it can have an astringent action on any of the other mucous membranes, such as the bronchial. It is now almost an axiom in therapeutics, that substances which do not possess a very decided general action, can affect only those mucous membranes by which they are excreted, and it is improbable that tannin is any exception to this.

With regard to its action on the kidneys, it is conceivable that it may have a favorable influence in diminishing albuminuria, but even this is to be regarded as doubtful. Many eminent clinicians have expressed disbelief in its value, and the only cases which I have been able to find, in which the amount of albumen in the urine was carefully estimated from day to day, tend to confirm this view. They are four cases of chronic Bright's disease reported by Briese (*Deutscher Archiv. f. klin. Med.*, xxxiii., p. 220, 1883) in which the administration of tannate of soda for long periods had no influence, either on the amount of urine or the albumen present in it.—*Brit. Med. Jour.*, Dec. 4, 1886.

Munk on the Action of Diuretics.—The great difficulty in experiments on the kidney in living animals, is that of estimating how much of the effect produced by a drug is due to changes in the circulation, or in the nervous system, which has an influence on the secretory activity of the kidney, as well as on the blood-vessels. Munk has, in his recent experiments, eliminated these factors by investigating the action of diuretic drugs on an excised kidney. The organ, after excision, was nourished, under a pressure of 100 to 190 millimetres of mercury, by a stream of blood and salt solution through the renal artery. The drug was added to the liquid, and its effect noted by the amount and quality of the urine, collected through a canula placed in the ureter. Before the addition of any drug, it was found that the amount of urine secreted in an hour varied from 4 to 24 cubic centimetres; that this was a true secretion, and not a simple diffusion, was shown by the fact that it contained a greater proportion of

saline constituents than the circulating fluid. The addition of chloride of sodium, nitrate of sodium or potassium, caffeine, dextrose, cane-sugar, or glycerine to the circulating fluid, increased the secretion of urine three to fifteen times, the pressure remaining the same; while in the case of nitrate of potassium and of caffeine, there was an increased rapidity of flow of the circulating fluid. Diuresis of this nature and under such conditions, could only result, according to Munk, from a stimulation of the secretory cells of the kidney by the drug, a conclusion which, as regards caffeine, had already been arrived at by von Schroeder, the appearance of hippuric acid in the secretion from the kidney, when benzoate of sodium and glycol were added to the fluid circulating through the vessels of the kidney. As is well known, benzoic acid given to any animal appears as hippuric acid in the urine; and this result has been supposed to be due to the action of the intact blood-corpuscles. But, in Munk's experiment, these were absent; hence he concludes that the transformation is probably brought about by the oxygen which is combined with the hemoglobin.—*Brit. Med. Jour.*, Dec. 11, 1886.

MEDICINE.

Terrillon on Neuralgia of the Testicle.—Neuralgia of the testicle, whatever be its local cause, is most often seen in persons having hysterical attributes which may be latent and have to be searched for with care, but which sometimes are very evident and general and manifested by regular hysterical attacks.

The knowledge of these facts is of the greatest importance as it is of much help in treatment.—*L'Union Méd.*, Nov. 16, 1886.

Dauchez on Vaccination Followed by Inflammation, Choleriform, Diarrhoea, and Death.—The writer vaccinated a perfectly healthy child of two years with healthy lymph. In a few days the child complained of malaise, fatigue, vagrant pains in the limbs, and at the same time became feverish, and was seized with vomiting and diarrhoea. The stools were watery, yellowish, and there was much epigastric pain. The vaccination point became enlarged and surrounded by a large dark red areola. There was at no time any enlargement of axillary glands.

The diarrhoea continued, the temperature became subnormal, the face and extremities pinched and cold, and death took place from collapse. A sister of the child was vaccinated at the same time and had no marked disturbance.

The mother of the child, however, was easily upset, and frequently had alarming diarrhoea from trivial causes.—*La France Méd.*, Oct. 26, 1886.

The Result of Dr. Shakespeare's Recent Investigations upon Cholera.

—During his stay abroad Dr. Shakespeare made personal visits to those whose labors have rendered them distinguished in this field; not only in several countries in Europe, but also in India. He gives brief accounts of recent epidemics of cholera in the different countries where it had been studied, and illustrated his remarks by diagrams of morbidity and mortality. The connection between the outbreaks of the disease and infected water-supply are clearly shown in nearly every instance.

Although the proof of the statement that the comma-bacillus is the active and efficient cause of cholera Asiatica was not entirely satisfactory to his mind, the lecturer felt no hesitation in declaring that Koch had conferred an inestimable boon upon the race by placing in the hands of every practitioner an infallible means of diagnosis of this disease from cholera morbus and other diseases resembling cholera. He expressed the opinion that a health-officer or physician who, in the presence of suspected cases and before the prevalence of the malady as an epidemic, should fail to employ this means of deciding whether or not the disease is genuine cholera, would be guilty of criminal negligence.

After a personal visit to Ferran, in Valencia, and an examination of his methods of investigation, he was prepared to endorse the verdict of the French Commission with regard to the condition of his laboratory, but as to Ferran himself he arrived at a different conclusion. He was impressed by his modest bearing, and believed him a cultured gentleman, possessed of no mean skill as a bacteriologist. In his laboratory Dr. Shakespeare found as pure cultures of the comma-bacillus, and as handsomely mounted and stained specimens, as could be found anywhere in Europe. A few of these slides, made in his presence, were exhibited after the lecture was finished.

With regard to the result of Ferran's inoculations, Dr. Shakespeare demonstrated by the official returns made by the government officers, who are not friendly to Ferran, that there was a sudden and marked reduction in the number of cases and in the mortality in several villages after the inoculations were begun,—this measure apparently having about six times the value of ordinary hygienic precautions in checking the epidemic. The facts concerning inoculation, so far as they have been reported officially, seem to indicate the importance of making, in future epidemics, this method the subject of a searching scientific investigation, such as it has not received up to the present time.—*Med. Times*, Nov. 27, 1886.

Osler (W.) on the Treatment of Pleurisy with Effusion by Hay's Method.—Dr. Hay found, when investigating the physiological action of saline cathartics, that if the salt was given in a very concentrated form, when the intestines of the animal contained very little fluid, it produced a very rapid concentration of the blood, owing to the abstraction of water to form the intestinal secretion excited by the salt.

Our usual plan is to order the patient to take nothing after the evening meal, and then, an hour or so before breakfast, the salt is given dissolved in as little water as possible. The sulphate of magnesia is preferable to the sulphate of soda, as it is more soluble. Four to six drachms in an ounce of water is the usual dose, but two ounces, or even more, may be given. The patient must not drink after it. This usually produces from four to eight watery stools without pain or discomfort of any sort.

The essence of the method lies in getting the strong salt into the intestine at a time when the fluid contents are scanty. The concentrated bitter solution excites a copious secretion from the intestinal glands, which distends the intestine and induces rapid peristalsis. Saline, as well as other purgatives, have long been employed in the treatment of dropsies, but this plan of Hay's is so simple, produces so little irritation, and at the same time acts powerfully, and, as you have seen, effectually, that with us it has superseded other methods in cases in which we wish the action of a powerful and prompt cathartic.—*The Med. News*, Dec. 11, 1886.

Reeve (J. C.) on a Case of Sudden Death from the Introduction of an Aspirator Needle.—The patient was a man of twenty-three, who had been ill for six weeks with symptoms of hepatic abscess. No anæsthetic was used. A point had been selected for the puncture a little over an inch to the right of the median line, and not quite two inches below the margin of the costal cartilages. The writer says: "I took a medium-sized needle of the aspirator and thrust it in at this point, upward and backward, to a depth of about three inches. As the stop-cock was turned, and I looked to see if pus appeared, my attention was attracted by the heavy breathing of the patient; I looked at his face, saw the head drawn to the left, the eyes turned and fixed, a slight convulsive tremor passed over his features, which bore the plainest impress of death. I found his pulse gone; no movement of his heart could be felt. After a brief interval of entire cessation of breathing, he drew one deep inspiration, which was the last manifestation of life. I should estimate the whole time from the puncture of the needle until he was gone at not over one minute and a half.

A partial post-mortem examination was made the next day. Upon opening the abdomen the liver was seen to be enlarged, reaching down to the level of the umbilicus. The puncture of the liver by the needle was plainly visible, surrounded by a small patch of ecchymosis. Upon lifting the organ up to remove it, an abscess of the right lobe gave way upon the under side near the centre, from which eight or ten ounces of pus escaped. The right auricle was extremely distended with blood. In texture the organ was somewhat softer than normal, tearing easily."—*Med. News*, Jan. 1, 1887.

Ouchterlony (J. A.) on a Case of Latent Pericarditis Purulenta, with Fatty Degeneration of the Heart, and Atheroma of the Ascending Aorta.—Henry Willis, aged forty-two, married, railroad man, was admitted to the Louisville City Hospital November 18, 1886.

Previous History. His father died, at the age of forty-five, of a destructive ulceration of the face, said to have been cancer. Four months ago his present illness began. He has used alcoholic stimulants in moderation, but has been excessively addicted to

smoking. His illness began with pain in the right epigastrium, rather constant and aggravated by the ingestion of food; he has also been much troubled with flatulence and other digestive disturbances, but had vomited only twice prior to his admission. His appetite had kept up tolerably well, but he has lost flesh steadily and in considerable amount.

The patient was rather tall and gaunt, eyes somewhat sunken, but bright; color rather good, certainly not suggestive of cachexia. He complained of a bad appetite and symptoms of indigestion as described above. The integument over the epigastric region was discolored over an oblong-square, which he said marks the site of blisters ordered by his former medical attendants. He complained of severe, deeply seated pain in this locality, shooting up under the sternum. There was tenderness under pressure, most marked at a point corresponding to the pylorus. Palpation revealed increased resistance, but no tumor could be detected. The liver appeared somewhat enlarged. He had no cough, but vomited several times after entering the hospital. Pulse was weak and slow. Temperature was subnormal, reaching but 98°. There was nothing abnormal observed about his chest.

The day after his admission he complained of very severe pains in the epigastrium and precordia. At 3 o'clock in the morning he was breathing hard; pulse was imperceptible at the wrist; his extremities were cold. The heart sounds were barely audible. His mind, however, remained perfectly clear. At 6 o'clock A. M., on the 20th instant, he died.

Autopsy. About five hours after death *rigor mortis* marked. Body thin, but not emaciated, moderate amount of fat in subcutaneous areolar tissue and omentum. Liver somewhat enlarged and congested; spleen full-sized, capsule opaque and thickened at various points; kidneys congested.

The pericardium was highly injected, and its cavity contained about two drachms of pus. The heart was distended and flabby, pale, fattily degenerated; left ventricle contained black, soft coagulæ, left auricle contained a very firm, white, fibrinous clot, entangled in the cordæ tendinæ of mitral valve. Aorta ascendens thickened from incipient atheroma; orifices of coronary arteries almost obliterated. No disease of the stomach was found. Dr. A.

Le-Coq made a careful microscopical examination, which revealed that muscular structure of the heart was in a state of advanced fatty degeneration.—*Am. Pract. and News*, Dec. 11, 1886.

Circulation in Ganglion Cells.—Professor Adamkiewicz, of Cracow, has recently published some observations on the circulation in ganglion cells, which, if confirmed, certainly adds to our knowledge of the physiology of nervous tissue. The ganglia chosen for observation were the intervertebral ganglia connected with the cords forming the brachial plexus. Carmine injections were made by means of the spinal arteries, and examination showed that each cell has a special arterial twig, which is distended so that its walls surround the ganglion cell, which consequently is situated in the lumen of the vessel, and is bathed completely by the arterial stream somewhat in the same way as the placental tufts are bathed by the blood in the maternal sinuses. This, however, is not all; for the cell itself contains a number of exceedingly minute vessels or passages from the circumference to the centre, which, of course, admit serum only; and this, which enters the cell in an arterial condition through numberless peripheral orifices, is collected at its centre as venous serum—forming, indeed, what has hitherto been looked upon as the cell nucleus,—which, therefore, instead of solid, is liquid, or rather a cell containing liquid, the only solid part being the nucleolus. This venous serum is conveyed away by a single vessel or vein which runs into the general venous circulation. Besides all this, it appears that the whole blood-vessel apparatus of the ganglion cell is surrounded by special lymph-vessels, so that the arrangement is highly complicated, and offers an interesting field for further research.—*Lancet*, Dec. 18, 1886.

Rotter and Virchow on Charcot's Joint Disease.—At the meeting of the Berlin Medical Society on the 17th ult. a discussion took place upon tabetic arthropathy, which, it may be remembered, excited so much attention at our clinical society two years ago. Dr. Rotter, who opened the debate, described succinctly the clinical and anatomical features of the disease, with a view of proving its distinct identity, and the dependence of the articular changes upon nerve disorder. Professor Virchow followed in a long and careful

speech, in which he acknowledged the similarity of the affection to rheumatoid arthritis, and traced the development of the pathological changes in the joints from hyperplasia of the cartilaginous investment, followed by regressive change and atrophy, ossification of the medulla leading to eburnation, hyperplasia, and ossification of synovial fringes, and ultimately of ligamentous tissues. These changes, he declared, were hardly to be regarded as inflammatory; but, although he admitted their dependence upon disordered nerve influence, he maintained that in each case there must be a local determining cause also at work. Other members also spoke, but we must postpone a full analysis of the debate to a subsequent occasion. Neurologists will note that Professor Virchow objects to the phrase "tabetic," and prefers that of "arthropathia tabidorum."—*Lancet*, Dec. 11, 1886.

The Differential Diagnosis between Chronic Rheumatic Arthritis and the Arthropathy of Locomotor Ataxia.—William Adams, in an article on "*Chronic Rheumatic Arthritis, Especially as Affecting the Hip-Joint*," adduces the following instructive points in differential diagnosis:

In chronic rheumatic arthritis, the structural changes are essentially those of hypertrophy. *In Charcot's disease*, the structural changes are essentially those of atrophy.

In chronic rheumatic arthritis, the affection commences in subacute or chronic inflammation of the synovial membrane, and fibrous tissues in the neighborhood of the joint, gradually extending to the articular ligaments, the periosteum, and the bone. *In Charcot's disease*, the affection commences in the bones, the osseous structure being the seat of the primary and essential changes all through. This affection may, therefore, properly be called osteo-arthritis.

With regard to the clinical history, *chronic rheumatic arthritis* is a painful affection all through its course, from its commencement to its termination. *Charcot's disease* is a painless affection throughout its course.

In chronic rheumatic arthritis, the pain complained of is always limited to the joint or joints involved, or to their immediate neighborhood. *In Charcot's disease*, shooting pains are complained of throughout the limb, and also in the opposite limb.

In chronic rheumatic arthritis, there are

no symptoms of febrile-disturbance, or any gastric symptoms; nor are there any pupillary symptoms, known by the name of their first observer, Argyll-Robertson. In *Charcot's disease*, all these symptoms are present, and diagnostic.

In *chronic rheumatic arthritis*, the reflex phenomena are present; and, when the knee-joint is affected in one limb, the patellar reflex is always present in the opposite limb. In *Charcot's disease*, the absence of the patellar reflex is one of its earliest and diagnostic symptoms.

Chronic rheumatic arthritis is characterized by very limited mobility of the joint affected, any attempt to increase motion being painful. *Charcot's disease* is characterized by increased mobility and a flail-like condition of the knee, hip, and other joints affected.

In *chronic rheumatic arthritis*, the progress of the affection is remarkably slow and chronic in its character, the articular changes being slowly developed in the course of some years. In *Charcot's disease*, the progress of the joint-affection is remarkable for its rapidity, extensive destruction frequently occurring within a few months.

In *chronic rheumatic arthritis*, the sufferers from this affection frequently live to an advanced period of life, not uncommonly reaching eighty years of age, or more. In *Charcot's disease*, as far as I can learn, old age is seldom reached, the patients either dying as paralytic cripples, from some disease connected with nerve-lesions, or from some intercurrent disease, the progress of which they are unable to resist.—*Brit. Med. Jour.*, Nov. 13, 1886.

Thomas (D.) on Shoemakers' Ulcer.—While holding an inquest recently on the body of a shoemaker who had died suddenly from the bursting of an ulcer in the stomach, Dr. Thomas said it was a pity that shoemakers persisted in pressing the boot to the stomach when engaged on their work, for the pressure was apt to produce an ulcer. We are informed by Dr. Lomas, an excellent authority on the subject, that a very large number of shoemakers suffer from stomach-diseases. Some years ago an upright bench for shoemakers was exhibited which, it is believed, is now used in many boot-factories. The repairers of boots and shoes are the people who still carry on their work in the old way. In hospitals and dispensaries, he has met with

some cases of hæmatemesis from pressure over the stomach. As a class, shoemakers are not healthy; many of them become very feeble at the age of forty to fifty.—*Brit. Med. Jour.*, Oct. 30, 1886.

Hall (de H.) on Hepatico-Bronchial Fistula.—This lesion occurred in a meat salesman, who suffered much pain in the hepatic region, followed by jaundice three weeks before he was seen. Vomiting of bright bile also occurred. An enormous quantity of bilious fluid was brought up at one time. The liver was enlarged, not tender; the urine was loaded with bile, the motions pale, and the patient jaundiced. The discharge of bilious fluid was continued, and it was evident that the bile came from the lung, as it was expelled by coughing and was frothy. The patient eventually recovered. In the majority of cases hitherto recorded hepatico-bronchial fistulæ had been caused either by the rupture of an abscess or of a hydatid cyst in the liver, and the discharge of their contents into the lung; but from the result of his investigations he would add the impaction of a gall-stone and consequent dilatation of the bile ducts as another cause of these fistulæ. Two of four cases ultimately died. The treatment must necessarily be of an expectant kind. If there were complete obstruction to the entrance of bile into the intestine, purified ox bile might be given with advantage. Should there be any difficulty in clearing the lung of the bilious fluid, a stimulating emetic, such as ten grains of carbonate of ammonium and twenty grains of ipecacuanha, might be required. The question of surgical interference might come into question if bile accumulated in the pleural cavity.—*Lancet*, Nov. 13, 1886.

White (H.) on Statistics of Cerebral Tumors.—An instructive piece of statistical work has been contributed to the current number of *Guy's Hospital Reports* by Dr. Hale White, on the cause, operative treatment, mode of death, and general symptoms of 100 cases of cerebral tumor collected from the post-mortem records of Guy's Hospital. Ninety-nine of the cases occurred during the years 1872-84, both inclusive; the total number of necropsies was 5,850, or about 450 a year, which gives 1 tumor of the brain for every 59 that come into the post-mortem theatre. Of the 100 cases, the growth was tubercular in 45, gliomatous in 24, sar-

comatous in 10, carcinomatous in 5, gliosarcomatous in 2, cystic in 4, gummatous in 5, lymphomatous in 1, myxomatous in 1, and of doubtful nature in 3; 34 of the tubercular cases occurred in the male sex. There is much useful information in the paper, but the chief drift of the investigation was to ascertain, as far as possible, how many cases could have been treated surgically after the fashion of recent times. The conclusion was arrived at that only 3 of the tuberculous cases could have been benefited by operation, that at the outside 6, and probably only 4, of the gliomata, 1 only of the sarcomata, none either of the carcinomata or of the gliosarcomata, perhaps 2 of the cysts, the myxoma but not the lymphoma, and 2 of the doubtful cases. Therefore, of the whole number of cases 10 might certainly have been operated upon, and probably 14. It will not be forgotten that before this number could have been treated surgically it would have been necessary to diagnose the seat of the tumor, even so late in the case as shortly before the death of the patient would suffice, whilst, of course, earlier in their histories many others might have been operated on with good prospect of success.—*Lancet*, Sept. 25, 1886.

White (H.) on Cerebro-Spinal Meningitis Causing Œsophageal Abscess.—The specimen, which was taken from the body of a girl, who was in Guy's Hospital for a month with retracted head, arching of the spine, cephalic and spinal pain, and other symptoms showing the existence of cerebro-spinal meningitis. About eighteen hours before death a quantity of pus began to pour from the mouth, but no cause for this could be discovered; the pus trickled down into the lungs, and the patient died. At the post-mortem examination, it was found that the spinal and cranial bones, dura mater, and cerebral vessels were all normal, without any trace of tubercle; there was abundant purulent meningitis of the base of the brain and the posterior surface of the spinal cord. Opposite the cricoid cartilage on its posterior surface, was an oval ulcer, with its long vertical diameter measuring $1\frac{1}{4}$ inch. At the bottom of it the cricoid cartilage was exposed, but was not necrosed. Opposite this ulcer was another on the posterior wall of the pharynx. There was some bronchitis, and the mitral valve was thickened. The rest of the body was healthy. The

œsophageal ulcers were probably due to an abscess which had existed at the upper part of the œsophagus at its junction with the pharynx, and this bursting had caused the discharge of pus noticed during life. It appeared that the cause of the abscess was the extreme retraction of the head throwing the larynx backwards and the spine forwards, so that the friction of the cricoid cartilage against the spine during respiration set up the abscess. The case was also of interest because it was possibly an example of a rheumatic meningitis, for the patient had had rheumatic fever twice, and there was no cause obvious at the post-mortem examination to account for the inflammation of the meninges.—*Brit. Med. Four.*, Nov. 20, 1886.

SURGERY.

Richardson on Gastrotomy for Removal of a Plate of Teeth from the Œsophagus; Recovery.—The patient was a powerful teamster, thirty-seven years of age, who applied for treatment at the Out-Patient Department of the Massachusetts General Hospital, on September 26, 1885. Three days before, while eating, he had swallowed his false teeth, which he described as "about the size of a silver half-dollar, carrying the four anterior teeth of the left upper jaw, and as leaving two small hooks by which it was fastened to the teeth still in that bone."

The plate was felt with a probang to be near the stomach. He was admitted to the hospital, where an unsuccessful attempt was made to remove the plate by means of a coin-catcher, but the end broke off and ten days later it was passed *per rectum*.

Two weeks later was given charpie cut fine, mixed with eggs. On November 10th, "was improving in health and strength, had good appetite and less pain," and was discharged from the hospital with the teeth still in the œsophagus.

July 23, 1886, re-entered the hospital and came under Dr. Richardson's care. The foreign body was in the same position as before, fourteen inches from incisor teeth. Patient had lost sixty-five pounds in weight, and could with difficulty swallow enough liquid food to keep alive. The operation is described as follows:

"August 5, 1886. Patient was carefully etherized. An unsuccessful attempt was

first made to demonstrate beyond possibility of a doubt the presence of the foreign body. Some difficulty presented itself in doing this, and the attempt was abandoned to save time. Moreover, it was not essential, as the probang had been used the day before in studying the location of the plate.

"An incision about six inches long was made one and one half inches below and parallel to the margin of the ribs in the left hypochondrium. It began at the other border of the *rectus abdominis*, three inches from tip of ensiform cartilage, and extended outwards and downwards. The abdominal wall was rapidly cut, layer by layer, until, all bleeding having been stopped, the peritoneal cavity was opened. The abdominal opening was held up by means of a T-hook at each extremity. The stomach was found lying empty in its usual position. An external examination was made of the cardiac orifice and of the whole stomach, to see if the foreign body might not be found and dislodged by manipulations. Nothing could be detected either in the stomach or the diaphragmatic opening. The stomach was now drawn out of the abdominal wound as far as possible, and placed upon a carbolized towel, and in this position all the subsequent manipulations were done. A small incision about one and one half inches long was first made through the anterior wall of the stomach, beginning near the pylorus, and extending upwards and backwards midway between the greater and lesser curvatures. The walls were very thick and vascular. After cutting through the peritoneal and muscular layer, a dense network of large and tortuous vessels came into view, which, on being divided, bled very profusely. This was controlled by smooth-bladed, hæmostatic forceps.

"After two unsuccessful attempts to introduce grasping instruments into the œsophagus through this small opening, I enlarged the incision sufficiently to admit my hand and forearm. The stomach was first wiped out with sponges and held with T-hooks. The walls of the diaphragmatic opening were found with some difficulty after passing the hand seemingly a very great distance. The middle and index fingers were then pushed up the œsophagus between the heart in front and aorta behind until the plate was felt, with the teeth pointing downwards, apparently embedded in a

mass of soft granulations. The hand was withdrawn, and long-bladed forceps introduced into the œsophagus, guided by the index finger, but attempts to grasp the plate were unsuccessful. I then reintroduced my hand, and by careful manipulation with the index finger succeeded in detaching the left extremity of the plate from its bed in the left side of the canal. The other extremity was then loosened from the right side, and the plate passed easily into my fingers, and was withdrawn from the stomach.

"The mucous membrane was united with a continuous silk suture, to control the hæmorrhage which followed the removal of the hæmostatic forceps. The peritoneal surface was closed with thirty-six fine silk sutures, after the method of Lembert, placed three-sixteenths of an inch apart, the line of union being most perfect and beautiful. The stomach was then dropped back into the abdominal cavity, and the external wound closed in the usual manner with interrupted deep and superficial silk sutures. Iodoform and gauze dressings were applied, with compression. Time of operation, one hour and a quarter."

On the third day patient coughed up about $\frac{3}{4}$ viii. of pus, and afterward smaller amounts. This is supposed to have come from an abscess about the œsophagus, which had ruptured during the manipulation into the lung.

Patient made a good recovery, and on October 25th resumed work as a teamster.

After the operation, Dr. Richardson made a number of measurements on the cadaver, and found the distance from the upper incisors, when the head is fully extended, to the opening in the diaphragm to be "about fifteen inches in fourteen subjects taken at random." He also found "the distance in a straight line from the centre of an incision five inches long, one inch below and parallel to the margin of the ribs on the left side, beginning at the outer border of the *rectus abdominis* to the œsophageal opening in the diaphragm, to be 7.55 inches."

In some subjects left œsophagotomy was done as well as gastrotomy, and the index finger of one hand passed through the opening in the neck could be made to touch the index finger of the other hand introduced through the stomach.

The article includes brief histories of all the cases that the author could collect,

and references to a number of other cases which may be summed up as follows, changing the cases of Polailon and Bernays, now reported in full, from the incomplete to the complete list: (1) 14 authentic cases where the stomach, uninjured and non-adherent, has been opened; of these 3 died. (2) 11 cases where the stomach was injured and adherent; with 10 recoveries and 1 death. (3) 8, the authenticity of which is doubtful, with 6 recoveries, 1 death, and 1 unknown.—*Bost. Med. and Surg. Jour.*, Dec. 16, 1886.

G. B. P., JR.

Bernays on a Successful Case of Gastrotomy, with Critical Remarks.

—The patient was a healthy man, thirty-eight years of age, who, to amuse some friends, used an ordinary table-knife a little more than nine inches long, to do the sword-swallower's trick.

The knife was introduced with the handle foremost, and when he released the blade for a moment, the knife was "pulled down" into the stomach. Vomiting soon followed, and the operation was done about an hour after the accident occurred. An incision five inches long was made in the linea alba between ensiform cartilage and umbilicus. No perforation was found in the stomach wall. The handle was near the pylorus, and it was grasped and carried out of the abdominal incision, where an incision five eighths of an inch long was made in the stomach, and the knife removed. The stomach wound was closed by five gut sutures intended to produce a direct union of the cut edges, which were buried by eight silk Lembert sutures; abdominal wall sutured; bichloride gauze dressing. Patient did perfectly well, and took his regular food on the tenth day.—*Medical News*, Jan. 1, 1887.

G. B. P., JR.

On the Rupture of the Tendon of the Long Head of the Biceps Brachii Muscle.—Dr. George H. Monks, in the *Boston Medical and Surgical Journal*, Nov. 25, 1886, reports four cases of this uncommon accident. All four cases occurred in men over fifty years of age. Two had had for several years rheumatism in the shoulder of the arm injured. One case was caused by a fall on "face and left shoulder"; one from 'shovelling snow into a city cart'; one from lifting a stove; one from an effort to prevent a heavy chest from falling. With this case there

was a subcoracoid dislocation of the shoulder.

The author says:

"A normal tendon, whose strength is in proper proportion with the parts connected with it, is very rarely ruptured. Cases are occasionally met with in the young and robust where this accident has occurred. A rupture occurring in those advanced in years, however, is a different matter. Here the tendon is presumably weakened by senile atrophy or shoulder disease, so as to require only a slight force to tear it through.

"All cases of ruptured long tendon of the biceps, no matter what the cause be, show essentially the same deformity. The belly of the affected muscle is unnaturally full, so much so at times as to suggest the idea of a tumor. Above the swelling is an abnormal depression, in which the tendon can be felt. The muscle, though apparently firmly contracted, is soft and flabby, and the patient is unable to make it as hard as the muscle of the other arm.

"One should, in *all cases*, be able to feel the tendon running upwards from the collapsed muscle in the direction of the bicipital groove. I mean in all cases except where that very rare injury, namely, rupture through the junction between the tendon and the muscle, has taken place. If we examine the outer head of the biceps muscle just as it issues from under cover of the deltoid, we find it is muscular, not tendinous. The tendon is entirely covered by the deltoid. If this tendon ruptures high up, the lower fragment slips down the groove, and can be felt below the margin of that muscle.

"The diagnosis of a rupture of the tendon during life, when the deformity is marked, is a simple matter. Where, however, a partial rupture or only a laceration of the sheath has occurred, the diagnosis is beset with difficulties, for the sign of most importance is entirely wanting, namely, the deformity. In such cases reliance must be placed on localized pain and tenderness, and altered function of the muscle following an injury, which would in favorable cases be likely to cause a rupture. Gerster has reported a case in which he considers that a partial rupture occurred."

"The treatment of ruptured biceps is rest. A circular bandage around the arm, below

¹ *New York Medical Journal*, vol. 27, 1878, p. 487.

the flaccid muscle, will raise it up slightly and tend to relieve the ruptured tendon of all unnecessary weight. The elbow should be kept at the side and the arm in a sling.

"Pain and disability may exist for months, though this is rare, but eventually the function of the part is pretty sure to be restored. The torn end of the tendon acquires a new attachment, upon which the muscle learns to act. We lack proof that such an arm will ever again be as strong as before the accident, but we may be quite certain that it will eventually be a useful one. Such being the case, operative interference, such as laying open the joint and suturing together the two torn ends of the tendon, is contra-indicated."

Dr. Morton, in the *Medical Times* of Nov. 13, 1886, also reports a case, which occurred in a man fifty years of age while shovelling dirt from a pit ten feet deep.

"I found upon examination of his arm that the long tendon of the biceps had been ruptured. The muscle was firmly contracted and in a state of spasm." This is contrary to what Dr. Monks describes.

"I cut down upon the muscle and found its tendon coiled up upon it like a worm. I cut off the frayed end of the tendon, and replacing it in a deep groove that I had cut in the deltoid (which I had exposed to the acromion), I stitched it deeply into the tissues of this muscle with catgut interrupted sutures. The usual dressings were applied, and the arm kept in a sling. That was sixteen days ago. The dressings have not been disturbed since; they will now be removed. You see the line of the incision, which has perfectly united. Some remnants of catgut sutures are lying upon the dressings, which are perfectly dry. Although the wound has healed, we will not allow the man to use his arm yet; he should not go to work again for another fortnight, but there is no need of keeping him in the hospital. He can report at the out-patient department, and carry his arm in a sling until the newly united tendon has united firmly in its new location."

The final result in Dr. Morton's case is not stated, but the treatment would seem much better adapted to restore quickly the function of the muscle than rest alone, allowing the torn end of the tendon to acquire a new attachment, upon which it learns to act, as advised by Dr. Monks.

G. B. P., JR.

Watson (F. S.) on Spontaneous Fracture of Stone in the Bladder.—

Dr. F. S. Watson reports in the *Boston Medical and Surgical Journal* for Dec. 2, 1886, the case of a man, eighty years of age, who, ten days before admission to the hospital, had an attack of retention of urine following exposure to wet and cold. His urine was drawn, and prostate found enlarged. The day before admission he had a second attack and a false passage was made. On admission to hospital, a silver catheter was introduced into the bladder and left drawing off "bloody alkaline urine." Patient soon developed urinary fever and died.

At the autopsy the bladder was found to be thickened and trabeculated, the prostate hypertrophied, both centrally and laterally. Behind the greatly enlarged third lobe, was a deep *bas fond*, formed by the bulging downward of the floor of the bladder, in the bottom of which lay the fragments of stone. The mucous membrane of the bladder was the seat of a hemorrhagic cystitis, and, in places, also of a diphtheritic membrane. The pieces of stone had peculiar characteristics, which at once attracted attention, and suggested, in the absence of a sufficient mechanical force from without, that their fragmentation was the result of spontaneous fracture. The weight of the whole mass was one hundred and sixty grains, and it is composed almost wholly of uric acid. Much of the stone consists of bits having no clearly defined form, and of sand; the rest of fifty six pieces, varying in size from a quarter to a whole good-sized pea. A majority of fragments show for the most part a smooth, convex back, projecting forward from which is a two, three, four, or many-sided body. The surfaces of these sides show a great similarity, and some of them can be made to very nearly fit into each other, and evidently would do so quite exactly in some instances, had not their angles and edges become somewhat rounded from having received a deposit upon them subsequent to their having separated. Four, however, were found which had fresh surfaces, showing a more recent splitting apart, which fitted each other in pairs precisely. The segmentation in this case seems to have taken place in two ways: by clefts radiating from the centre, and by the separation of the outer crust or layer from the one below it. The introduction of a silver catheter was

the only force which could have acted upon the stone in this case from without, and this would have in all probability been insufficient to accomplish its disintegration; and, moreover, we have evidence in the rounded angles of most of the fragments that they must have lain in the bladder for a longer time than sixteen days, which was the time from the first introduction of the catheter to the patient's death. In view, therefore, of this fact, and of the forms of the fragments, which show, I think, conclusively, that the fragments originally belonged to one or more stones, we are justified in assuming that they represent the spontaneous rupture of stone in the bladder.

Dr. Watson advances no theory as to the cause of fracture. In the same journal, under date Dec. 9th, appears the following:

BOSTON, December 4, 1886.

MR. EDITOR: Friable stones are no doubt broken by the contractions of a thickened bladder, much as English walnuts are in the hand. In the Harvard Medical School Museum, there was a mass of little calculi from a patient, I think of the late Dr. Gay, which I supposed to have been so comminuted. There may be other causes of "spontaneous fracture," but this is probably a common one.

Very truly yours,

H. J. B.

On page 83, vol. iv., of Prof. Albert's "Surgery," is the following, as freely translated: "Spontaneous fracture of a stone in the bladder is brought about by a metamorphosis. If a uric-acid calculus lies in ammoniacal urine, urate of ammonia is formed. This has, however, a greater volume than uric-acid, thus causing a fissure in the calculus, just as water changing to ice can split a rock. A stone can be in this way so split up that it falls in fragments.—G. B. P., JR.

Removal of a Tumor from the Cerebellum.—On October 30th, Mr. Bennett May removed a tumor from the cerebellum of a child under the care of Dr. Suckling in the Queen's Hospital, Birmingham. The child had been in a condition of stupor for some weeks, and was growing rapidly worse. The tumor, as had been diagnosed during life, was situated in the right lobe of the cerebellum. The operation was performed on the lines laid down by Mr. Victor Horsley, but the child only survived three hours. The

growth, we are informed, was tubercular.—*Br. Med. Jour.*, Nov. 6, 1886.

St. Clair (R. M.) on Treatment of Chronic Ulcers.—Mr. Y. came to me with an ulcer of twenty years' standing. The edges were deep, partially undermined, with a foul, unhealthy bottom, studded with fungous granulations. Ulcer about five inches long by four wide. I dressed it with a poultice of cow's horn scraped fine with glass. This in twenty-four hours cleaned out the fungous granulations. With the hot platina wire I burned through the hard edges (instead of the knife), then with a small brush applied tinct. ferri chloridi. The latter was applied once a day, more or less, as needed. Iron and quinine internally in full doses. In three months the leg was entirely well. The iron forms a crust over the whole, which is left, till it begins to come off itself.—*The Medical Summary*, Oct., 1886.

Fifield on a Unique Case of Dislocation of the Ribs.—A boy about eight years old, standing near a pedler's wagon, was thrown down by some children underneath the hind wheels of the wagon, the horse started forward, and the wagon wheel went over the child's chest, over the left chest in front. Perhaps half an hour after this, I saw him. There was then a dislocation of some three of the ribs, I don't remember the exact ribs, near the region of the heart; a dislocation forwards, the cartilages of the ribs lying behind, the ribs projecting in front. The child was described as having been very blue, livid, and gasping for breath shortly after the accident. When I saw him he was breathing with considerable ease, but upon any attempt being made to push the ribs backward into their places, he again grew livid, and respiration threatening to cease, I was obliged to desist from my endeavors. I think I tried twice in this way and on each occasion the interference of respiration made me let it alone.

There was obviously no way of placing the cartilages in any position, except by cutting a hole, and putting the hand in. I advised to have him left entirely alone, hoping that this would restore the position. The following day the projection of the ribs was not so noticeable and within three days the projection had almost entirely disappeared, and the cartilages had resumed very nearly their natural place.—*Boston Med. and Surg. Jour.*, Nov. 11, 1886.

Daggett (W. G.) on a Case of Backward Dislocation of the Foot without Fracture.—J. D., aged fourteen, while wrestling with a school-mate, fell in such a manner that his foot became fixed, and the weight of his opponent, who fell on top of him, was spent on the leg above the ankle. The resulting injury was a backward dislocation of the astragalus, together with the rest of the foot. The dislocation was easily reduced. Repeated careful examinations by Dr. Francis Bacon and myself disclosed no fracture of tibia or fibula. There was no unusual injury to the soft parts.—*Med. News*, Dec. 18, 1886.

Burchard (T. H.) on Pelvic Abscess in the Male.—In employing cold in this or any other inflammatory condition about the rectum, nothing equals in efficacy and comfort, in my experience, the continuous use of cold water, which passes up and immediately returns through a double flow blind tube. The great mistake that is often made by the inexperienced in the application of either such an instrument or the ice-coil, is in applying it too cold at first. The water at first should be warm, then gradually cooled until ice-water can be used with astonishing relief. During acute inflammation frequent rectal explorations should be desisted from, as calculated to do more harm than good. After suppuration may reasonably be suspected, a careful examination under anæsthesia should be made in order that the abscess may be evacuated into the rectum at the earliest possible moment. If evidence of internal suppuration persist, and there is reason to believe the pus to be burrowing upward, an abdominal exploratory incision is obviously demanded.

If this can be made without opening the cavity of the peritoneum, it certainly should be done. The object to be attained, however, is the evacuation of the pus. We cannot be always successful in this. Adhesions will form impossible barriers at times.—*N. Y. Med. Record*, April 24, 1886.

Fenwick (H.) on Carcinoma of Vesicula Seminalis.—The case was one of carcinoma of the left vesicula seminalis, which had probably originated in the posterior part of the left lobe of the prostate, and had involved the bladder and the vesicles secondarily. The chief symptoms, which were of nine months' duration, were great frequency of micturition, and finally incontinence. Death was due to

frequent and profuse attacks of vesical hemorrhage; no growth was observed in the urine. No secondary deposits were found on post-mortem examination.—*Brit. Med. Jour.*, Nov. 20, 1886.

Younge (G. H.) on Contusion Over the Sacrum—Suspected Injury to the Vesiculæ Seminales.—G. H. came under my care August 28, 1886. The previous day, while out riding, he had been thrown from his horse on to some hard ground. When I saw him, I found a severe contusion over the sacrum. There were great swelling and echymosis, but no signs of any deeper injury. Under rest and warm fomentations these disappeared in about a week; but, for some time afterwards, soreness and stiffness of the adductor muscles of both thighs remained. About ten days after the accident, he began to suffer from priapism, with nocturnal emissions. On the first occasion on which the latter occurred, he was greatly alarmed to find, on getting up in the morning, that his night-clothes were deeply stained with blood. On the second occasion I was able to examine the semen. It was of a deep reddish-brown color, and appeared to consist of small semi-isolated masses. These showed little tendency to coalesce. Under the microscope, the color was seen to be due to broken-down blood corpuscles. The emissions continued for about a fortnight, till the semen gradually became normal in color and appearance; then they ceased. There can be little doubt that these symptoms were due to contusion and perhaps rupture of a small blood-vessel within, the vesiculæ seminales. I believe they were quite independent of any injury to the spinal cord. The only treatment adopted was rest.—*Brit. Med. Jour.*, Nov. 20, 1886.

Tappan (J. G.) on Œdema of the Prepuce.—For several years I have been treating the great œdema and infiltration attending many cases of phimosis and paraphimosis as the result of congenital or specific causes in the following way: I saturate a given quantity of absorbent cotton with chemically pure glycerine in which bichloride of mercury has been dissolved in proportions varying from 1 in 1,000 to 1 in 5,000, according to the amount of fetor present; or, in place of the bichloride, iodoform, carbolic acid, or any antiseptic agent preferred may be used. With the cotton so charged I completely

encircle the organ so far as it is involved. Over this I draw a large rubber condom, which is then suspended from an abdominal band. This dressing is to be repeated every six hours until the cedematous condition disappears. At that a beginning pallor will be observed, and often in from twelve to twenty hours the prepuce will have become very pale and shrivelled. The great majority of cases yield promptly, and no further progress is observed after the first application. If ulcers are present, it will often be discovered that they have taken on a healthy action before it has been possible to expose them, and not infrequently this progresses until the cure is completed.—*N. Y. Med. Jour.*, Nov. 6, 1886.

Hockenhull (J.) on the Removal of Stones from the Rectum.—On May 29th of the present year Mr. C— called on me to go and see his son, about seven years of age. I found him a stout healthy-looking boy, but his parents informed me that during the preceding day and night he had been suffering occasional tenesmus, which they thought was caused by the bowels being obstructed with rocks, the mother having extracted ten small ones from the rectum during the night. I had him placed in a prone position across his father's lap, and on introducing my finger into his rectum I found small hard stones, from the size of a pea to that of the end of the little finger, firmly impacted, forming a wall that completely obstructed and distended the rectum. I had some difficulty in dislodging the first few stones, but I soon extracted them from the rectum in such rapid succession that in a short time I had taken out one hundred and eight. He then had some natural evacuations of his bowels, the dejections being mixed with stones, and before I left three hundred and forty had been discharged. The stones were of the sizes before mentioned, of black color and a hard, flinty nature, such as are seen among sand that has been frequently subjected to the action of water. His father a few days after my visit informed me that the total number of stones passed were four hundred and two. He suffered no further inconvenience and is now well.—*Atlanta Med. and Surg. Jour.*, Nov., 1886.

The Elastic Bandage in the Reduction of Incarcerated Hernia.—In the *Brit. Med. Jour.*, May, 1886, p. 873, Mr. William Elder describes a case of irre-

ducible inguinal hernia, which was treated by Professor Chiene and the author by means of elastic pressure.¹ The patient was a man, aged fifty-six, who had suffered from a small hernia for thirty years, but it had only given him trouble during the last few months. On June 30, 1885, the hernia came down, and he was unable to reduce it. The swelling was found to consist partly of bowel, and partly of omentum. The omentum was much indurated, and it was found impossible to reduce it, though the bowel was reduced. The patient was then put to bed and kept absolutely quiet, whilst ice was applied to the part. Next day, an attempt was made to reduce the hernia under chloroform, but without success; and the day following elastic pressure was applied by means of a padding of salicylic wool and an elastic bandage in form of a single spica. This pressure was kept up for about a week, and the hernia was very much smaller and softer; but the bandage slipped off one night, and next morning the hernia had increased in size considerably. The bandage and pad were reapplied, but in the form of a double instead of a single spica, and in a few days the hernia had completely disappeared. A truss was then fitted, and the patient soon regained his health, without suffering from any return of the rupture.

Dr. W. A. Lockett, of Brenham, Texas, reports a similar case, the hernia² being of the inguinal variety.

The patient, a large stout man, about thirty-five years old, had been suffering from complete strangulation for twenty-four hours. The scrotal sac was as large as an infant's head at a year old, very hard and tense. Taxis, the knee-chest position, suspension with head down, and various other methods had been tried in vain. His condition was becoming serious. I had in my pocket a Martin's india-rubber bandage. I took the scrotum in my left hand to steady it, and began with the band at the distal end to strap, making strong tension, and as the strapping approached the canal in a spiral manner, decreased the tension. I then wound the band back to the distal end, increasing the tension. In five minutes of this steady and expulsive pressure, I had the satisfaction of seeing

¹ Neale in *London Med. Record*, June 15, 1886.

² "A New Method in Incarcerated Scrotal Hernia," Daniels' *Texas Med. Jour.*, Nov., 1886.

the sac diminishing, and suddenly the whole collapsed with a gurgle, and the reduction was complete.

In the *Vratch*, No. 35, 1886, p. 630, Dr. D. P. Nikolsky relates the case of a strong muscular iron-worker, aged sixty-five, with a right inguinal rupture of twenty years, standing, which suddenly became incarcerated, and could not be reduced either by ordinary taxis, or by either irrigations after Finkelstein's method, or by manipulations after warm baths.¹ The man suffered greatly from pain and sickness. The author, who had been called to the patient about thirty hours after the strangulation, tried again taxis, as well as electrization for half an hour, but did not succeed in making any impression on the swelling, which was as large as an infant's head. Before resorting to herniotomy, he resolved to give a trial to elastic bandage. The latter caused local pain, which circumstance induced the patient to remove the bandage in an hour or so. About ten minutes later, however, hernia disappeared spontaneously.² In the *Vratch*, No. 44, 1884, p. 741, Dr. M. P. Jakovleff contributes six cases of incarcerated, oblique inguinal hernia in which, after taxis had failed, an elastic bandage was applied after Maisonneuve's method. In five the tumor was reduced in ten or twelve hours. In the remaining case the bandage failed to give any relief, and herniotomy was ultimately performed. Discussing the use of Maisonneuve's method, Dr. Jakovleff comes to the conclusion that it is contra-indicated in cases—(1) where local and general symptoms point to gangrene of incarcerated intestine; (2) where the patient's urine contains considerable amounts of albumen; (3) in cases of incarcerated "interstitial" inguinal hernia of Tillaux; and (4) in cases where elastic bandage gives rise to intense pain. Speaking generally the longer incarceration has existed, the less successful results may be expected from the use of the bandage under consideration. At all events, when a ten-hours' application of the bandage has failed to bring any improvement, reduction may be effected only by herniotomy.

Moyer (H. N.) on a Case of Injury from a Strong Electric Current.—On the evening of August 5th last I was called to see S. C., a laborer, well developed,

muscular, and of a healthy, robust appearance. I found him lying in bed bathed in a cold perspiration. His skin was pale and of a leaden, ashy hue. The pupils were widely dilated and reacted but feebly to light. He was partially delirious, though when pressed to do so he would give fairly rational answers to questions. His pulse was about 100, feeble, and slightly irregular. The heart-sounds were normal, though its action was somewhat hurried and irregular. His temperature was $97\frac{1}{4}^{\circ}$ F. Nausea and vomiting were constant; every thing taken into the stomach was immediately rejected. On the outer aspect of the knee, about one inch from the patella, was found an oval opening three fourths of an inch long and one half an inch wide, extending below the deep fascia. The opening had sharply defined edges which were not everted. The opening showed an actual loss of substance, as though made with a punch. There was very little hemorrhage at that time, and it was stated that there had been but little. On the posterior aspect of the thigh, in the middle line, just above the popliteal space, a round, button-like eschar, about one half an inch in diameter, was found. The eschar was of a blackish-brown color, and seemed to involve only the skin, and to be freely movable on the tissues beneath. Careful examination failed to reveal any displacement of the bones or ligaments, but I was unable to assure myself that the synovial membrane of the joint was not involved in the solution of continuity. At the hospital the wound healed kindly, and in a few days he was again on the street. The eschar on the posterior aspect of the thigh separated, leaving a deep fistulous tract extending forwards and downwards, which at the end of five weeks had not yet healed, and long after all other evidence of injury had disappeared.

It was after the patient left the hospital that I obtained full particulars of the manner in which the accident occurred. He was engaged in adjusting one of the arc lights of a thirty-light circuit of the Van De Pøle system. At the time he was standing on a step-ladder a few feet above the sidewalk, his foot slipped, and in attempting to save himself he grasped both of the side wires of the lamp. For an instant at least a portion of the current passed through his body. It is hardly conceivable that a current of this intensity

¹ Neale in *London Med. Record*, Dec. 15, 1886.

² See also *London Med. Record*, Oct., 1884.

could pass through the body without causing instant death, and I am of the opinion that a portion at least must have still passed through the lamp. In falling, his knee came in contact with an iron railing, and the current was grounded. As he expressed it, "the fire flew from my knee to the rail." The injuries above described were directly due to the passage of the current from the leg to the rail.—*Chicago Med. Jour. and Examiner*, Nov., 1886.

DISEASES OF THE NOSE AND THROAT.

Brown (H.) on Tonsillitis in Adolescents.—The liability to tonsillitis during the evolution of the generative organs is shown by the fact that 105 of 127 consecutive cases were between fourteen and seventeen years of age. Seventy-six of 127 gave a personal or family history of rheumatism, while 20 presented the "rheumatic aspect," a combination of dark hair, fair skin, red cheeks, and thick lips. The contagious nature of follicular tonsillitis is illustrated by several cases, and the influence of sewer emanations in promoting the spread of the disease is dwelt upon. The relation of this disease to the development of cardiac symptoms is especially considered. Of 345 cases, none of which had previously suffered from rheumatic fever, 8 had endocardial lesions which terminated in chronic valve disease, 3 had pericarditis, 10 had the physical signs of mitral regurgitation which disappeared, and 8 had functional murmurs due to anæmia.—*Med. News*, Phila., Jan. 8, 1887. C. H. K.

Lastra (R. S.) on Lupus of the Throat.—The patient was a man of sixty. He informed me that he had commenced to suffer with his throat about one year before, and that during that period he had been unable to feed himself except with milk and broth, as the swallowing of any solid food gave him a good deal of pain.

On examining his mouth I found his tongue covered with psoriatic scales; the palatal mucous membrane tumefied, lumpy, and of a wine-red color; the right arch, tonsil, and pillars being ulcerated, the ulcer extending inferiorly to the pyriform fossa and superiorly to the middle of the uvula, and involving one half of the structure, anteriorly to within half an inch of the palatal border, and penetrating into

the submucous tissue. Its borders were red and swollen; its surface was nodular, irregular, and of a hard, elastic consistence. There was some pain upon palpation, but bleeding was not occasioned. The patient felt no trouble whatever, either in talking, or while coughing, or swallowing any liquid.

From the moment I took charge of the patient I prescribed a potion containing sodium arseniate, to be taken in gradually progressive doses; gargles with a solution of resorcin; and powdered iodoform, to be applied to the ulcer after having it washed with a solution of borax. For a month the ulcer continued to extend in periphery and in depth until it had destroyed more than one half of the uvula, a great part of the soft palate, and the amygdalæ, as well as a portion of the pharynx.

When I had lost all hope, the ulcer suddenly stopped its progress, and became covered by healthy-looking granulations of good consistence; cicatrization commenced to take place, and was finally completed in three months, some irregular scars remaining, depressed in some places, prominent in others, partly discolored at intervals, red at others, soft here and hard there, the posterior being adherent to the pharyngeal wall. The lingual psoriasis still kept on. Deglutition became normal again, and my patient's restoration to health took place in a short period. It is now more than a year and a half since the occurrences narrated, and Dr. Pizarro's cure still holds good.—*N. Y. Med. Jour.*, July 10, 1886.

Morgan (E. C.) on Hemorrhage Following Uvulotomy.—A fatal or uncontrollable hemorrhage has in one instance followed a uvulotomy.

A persistent, obstinate, or alarming hemorrhage is only encountered in the rarest instances.

A moderate bleeding, ceasing spontaneously or by the use of mild styptics, occasionally happens.

The loss of a few drops of blood at the time of operating, followed by slight oozing, is of common occurrence.

The most reliable surgical methods for controlling uvular hemorrhage are the ligature, compression by the clamp or forceps, or the use of the galvano or actual cautery.

The most reliable styptics are, in the order named, solid silver nitrate, or iron persulphate directly applied to the bleeding stump, and solutions of gallo-tannic acid,

or alum. To these may be added the local use of ice, ice-water, and vinegar.

The most reliable systemic means are opium, lead acetate, sulphuric acid, and ergot.—*N. Y. Med. Jour.*, Oct. 23, 1886.

Paget (S.) on Tumor of Palate.—

The tumor was undoubtedly innocent, yet it contained large masses of epithelial cells and cell-nests. Mr. Walsham had lately removed a similar innocent tumor from the same situation; it also contained cell-nests. In both tumors there were indications of glandular structure and tracts of embryonic tissue. The existence of cell-nests in tumors which were undoubtedly innocent was a point of great pathological interest. These tumors of the palate were closely allied to those occurring in the parotid region, and were probably examples of included embryonic vestiges.—*Brit. Med. Jour.*, Dec. 11, 1886. C. H. K.

Nasal Calculus.—In the *British Medical Journal*, Dec. 11, 1886, T. H. Headley reports a case of rhinolith weighing 720 grains, measuring two inches by seven-eighths of an inch, and having the appearance and almost the consistence of ivory. It was removed by separating the nose from the attachments on the left side. At the recent meeting of German naturalists and physicians in Berlin, two rhinoliths were presented by Koehler, one having a piece of wood for a nucleus, the other having no nucleus, but measuring three centimetres by one or two centimetres and weighing eighty-five grammes. Similar cases were referred to by Morelli, Schlesinger, and Schmidt.—*Rev. mens. de Laryngologie*, Dec., 1886. C. H. K.

Papilloma of the Larynx.—An interesting case is reported by Dr. Alex. W. MacCoy. The youth of the patient, eight years, and the extent of the neoplasm, involving the left and part of the right vocal band, and also springing from the angle of the thyroid beneath the anterior commissure, make rather an unusual history. After complete avulsion of the growth with Mackenzie's laryngeal forceps, "at various sittings," chromic acid was applied. Two years after the operation the voice remained perfect, and the larynx appeared normal. The growth was removed before the days of cocaine, without training the larynx, and preliminary tracheotomy was dispensed with.—*Med. and Surg. Rep.*, Phila., Nov. 20, 1886.

In the *Provincial Medical Journal* of

Dec. 1, 1886, may be found the notes of a case, reported by Dr. Hodgkinson, of multiple papilloma of larynx. The tumors sprang from three independent bases, namely, the anterior two thirds of left vocal cord, the region immediately beneath, and the opposite side of the larynx. The patient, a woman, aged forty, was completely aphonic and suffered from dyspnoea. Applications of the galvano-cautery on several occasions gave marked relief. Four months later there were symptoms of recurrence, and the tumors were found to be more extensive and apparently malignant, but microscopic examination proved the contrary. Tracheotomy was followed by immediate relief of the dyspnoea and by gradual decrease in size of the growths, thirty or forty small nodules being coughed up.

C. H. K.

Clubbe (C. P.) on a Case of Thyrotomy.—The remarkable feature of this case is that the operation was twice repeated within two years, on account of recurrence of a sub-glottic neoplasm. The patient, a boy four years old, had had dysphonia for five or six months and dyspnoea for about five weeks. The trachea was opened, and in the course of a few days a successful laryngoscopic examination was made. Repeated attempts to remove the growth with forceps failed. The thyroid cartilage was finally divided, and the growth was removed piecemeal through the wound. Its character and exact location are not mentioned. It is estimated to have been about the size of a hazel-nut. Bleeding was controlled by means of a weak solution of perchloride of iron. The trachea tube was not removed for nearly six months. A year later the voice was quite normal, but shortly symptoms of recurrence were presented. After an interval of eighteen months, the operation was repeated in the same way, except that the site of the tumor was touched with modified nitrate of silver. The external wound was closed, as before, with a harelip pin. Three months later a third thyrotomy was done, and a strong solution of chromic acid was applied to the base of the tumor. In this case the trachea tube was removed on the twelfth day, and on the sixteenth the boy could speak in a loud whisper.—*Australasian Med. Gaz.*, Nov., 1886.

In the *N. Y. Med. Jour.*, Nov. 20, 1886, Dr. G. B. Hope recommends as a substitute for tracheotomy in laryngeal

stenosis from paralysis a thyrotomy exposing widely the larynx and a careful ablation of so much of the paralyzed cord, together with any other overhanging tissue as seriously obstructs the lumen of the glottis.

C. H. K.

Cases of Laryngeal Œdema.—At the eighth annual congress of the Am. Laryngological Ass'n, Dr. T. A. De Blois, of Boston, read a paper on the above subject, and reported fourteen cases of his own, to which were added two previously reported, one by Dr. Gordon, of Brooklyn, and the other by Dr. Edes, of Boston. All the cases were acute; in many of them the œdema was very limited, and in several it occurred in connection with tuberculosis or syphilis. In but few were any alarming symptoms presented. The author advises astringents and, if necessary, scarification, believing that tracheotomy may thus often be avoided. If relief is not obtained, the latter operation may be resorted to (intubation?). Charazac, the author of an elaborate monograph on this subject, advises against scarification in secondary cases, and in chronic cases advises counter-irritation. Schiffers applied chromic acid (1-10) with good results in reducing œdema. The use of catheters in the larynx has been advised by Héring, McEwen, and Izcpawowicz.

C. H. K.

Œdematous Laryngitis; Tracheotomy; Glossitis Terminating in Abscess; Severe Hemorrhage from Tongue; Recovery.—This case, which is reported by D. H. Charles, M.D., *Brit. Med. Jour.*, Nov. 6, 1886, had several very extraordinary features. The patient was a healthy man, forty-four years old, who gave a history of having had several attacks of "sore throat," following exposure during the month preceding the time when he was first seen by the reporter. He then had an attack of acute œdema, involving the soft palate, tonsils, epiglottis, and ventricular bands, the vocal bands not being visible. The parts were swabbed with a solution of nitrate of silver (one drachm to the ounce), which gave great and almost immediate relief. Ten hours later, laryngo-tracheotomy was performed for relief of dyspnoea, caused by œdema glottidis, the patient being almost asphyxiated at the time. The next morning the patient respired easily, but could not swallow nor speak, owing to great swelling of the tongue, which filled the cavity of the mouth and projected between

the teeth. Two incisions were made into the tongue, and the following day, the swelling having increased, a third cut was made on the right side of the organ, and about an ounce of blood removed. The swelling gradually subsided, but on the fourth day "the tongue burst," and discharged a quantity of offensive matter. The discharge of pus and grumous matter kept up for five days, when there occurred a sharp hemorrhage from the tongue, lasting nearly an hour. The source of hemorrhage was not discovered. Some time after the bleeding had spontaneously ceased, the space between the tongue and the gum on the right side was stuffed with lint soaked in perchloride of iron. The next day an almost fatal hemorrhage took place, and the possibility of being compelled to ligate the external carotid artery was suggested. As the blood seemed to well up from a ragged cavity at the root of the tongue on the right side, tincture of pernitrate of iron was applied, and the cavity was stuffed with lint. Iron, digitalis, and ergot were given internally. During the following five days three slight recurrences of hemorrhage took place, but the patient then advanced rapidly to recovery. The only sequelæ were some difficulty in articulation and inability to protrude the tongue, the right side of which remained warted and shrunken. The idea that the affection may have been primarily an inflammation of the base of the tongue is discarded, although the history of the case strongly supports such a view. The author rather adopts the theory that the abscess of the tongue was a complication, the inflammation having begun in the larynx, involving the epiglottis, and thence extending to the tongue. The subsequent deformity of the tongue is attributed to loss of muscular tissue and adhesions. It seems hardly possible to follow the author to his conclusion. It is much more reasonable to hold, and all the symptoms would be easily accounted for by such a diagnosis, that this was a case of inflammation at the root of the tongue. We are told nothing as to the condition of the larynx during convalescence, and it is inconceivable that so severe a degree of laryngitis would disappear so promptly and require so little attention as seems to have been demanded in this case.—*Brit. Med. Jour.*, Nov. 6, 1886.

C. H. K.

Saundby on Paralysis of the Abductors of the Larynx in Locomotor

Ataxy.—The above condition occurred as one of the first noticeable symptoms of ataxia, and was referred to a crushing injury to the head eight years previous. The patient, aged thirty-eight, was admitted to the Birmingham General Hospital, in the service of Dr. Saundby, complaining of extreme dyspnœa. In addition to signs of serious pulmonary trouble the man was found to have no patellar reflex on either side; marked ataxic gait; inability to stand erect with closed eyes; and insensibility of the pupils to light. On deep inspiration the vocal cords became but slightly separated (paralysis of posterior crico-arytenoids), during phonation approximation of their posterior third was incomplete (partial paralysis of the lateral crico-arytenoids). There was a moderate degree of congestion of the larynx. Tracheotomy was advised, and became imperative six days later. Death occurred within twenty-four hours after the operation. At the autopsy gray degeneration of the posterior columns of the cord was visible to the naked eye. Under the microscope this could be traced up to the medulla, involving in that region the posterior pyramid and the restiform body, while the recurrent laryngeal nerve was in a state of chronic interstitial neuritis, its fibrous tissue being much increased with proliferation of nuclei, its blood-vessels enlarged and thickened, and the nerve-fibres narrowed and in parts obliterated by the fibrous overgrowth. In the left lung there was considerable bronchiectasis, with patches of lobular pneumonia and emphysema. The right lung was œdematous and congested. The brain was normal. The fact that the muscles of abduction were more completely paralyzed than those of adduction is explained by the fact that the former are supplied by the recurrent laryngeal nerve, the muscle of which is seated in the cervical cord, where the sclerosis was well marked. The latter are furnished also with fibres of the glosso-pharyngeal nerve, which come from the medulla, where the lesion was less advanced. — *Birmingham Med. Rev.*, Dec., 1886. C. H. K.

Porter (W.) on Erysipelas of the Upper Air-Passages.—The author believes that the unrecorded cases of erysipelas in the pharynx and larynx are many. Admitting the infectiousness and inoculability of erysipelas, the exposed position of the mucous membrane in these regions, its vascularity, and the frequency with

which it is eroded, must render it peculiarly liable to erysipelatous inflammation. Attention is called to the migratory tendency of the inflammation and to the constitutional symptoms; features which characterize cutaneous erysipelas and which serve to distinguish this disease, when involving mucous membranes, from ordinary acute pharyngitis and laryngitis. After referring to the cases of Delavan, Rohé, and De Blois, the author reports a second case of his own, which resulted fatally from pulmonary œdema. The inflammation began in the fauces of the patient, a man, twenty-six years of age, a few days after having driven some twenty miles on a chilly, wet day to see a sister dying from erysipelas. The second day tracheotomy was done for the relief of dyspnœa resulting from laryngeal œdema. Death occurred on the following day from extension of the disease to the lungs.

Cohen says that he has been able to find records of not a single case saved by tracheotomy. The author suggests that cocaine may be of service in reducing and quieting the swollen mucous membrane. If necessary, for relief of dyspnœa, operative interference is recommended; first, scarification, and finally, tracheotomy or intubation. — *New Eng. Med. Monthly*, Nov. 15, 1886. C. H. K.

DISEASES OF THE EYE.

Burnett (Swan M.) on Case of Black Cataract.—Patient, a colored woman about sixty-five years old, presented herself at the Central Dispensary about two weeks ago. She said she had lost the sight of her eye two or three years ago. Dr. Burnett thought vision had been lost a longer time, but had not been noticed by the patient. The diagnosis of cataract is usually made with great facility, as the pupil presents a white or grayish appearance. In this case, however, the pupil was black. On examining with the ophthalmoscope an obstruction was discovered, but its nature was in doubt. There is only one test getting reflection from the surfaces of the crystalline lens. It is somewhat difficult to differentiate between black cataract and the effusion of blood into the vitreous chamber. The patient was sent to the Garfield Hospital, and the lens was removed, cocaine being used. An iridectomy was first made.

The incision was large and the lens came out in its capsule. No vitreous humor escaped. Complete recovery without reaction. The lens measured 8.5 mm. by 2.5 or 3 mm. Its size approximated that of the lens in the healthy state. This was the first case of black cataract that Dr. Burnett had seen, but in a week he again saw two in one patient.—*Four. Amer. Med. Ass'n*, Nov. 20, 1886. A. T. M.

Taylor (C. B.) on Neurectomy as a Substitute for Enucleation.—It is popularly supposed that the eye has been often removed and again inserted with improved sight. Though the public is mistaken, it is a fact that even transplantation accomplishes much that seems impossible. Dr. Taylor then presented cases of the operation of neurectomy. There are three principal methods of performing this operation: Landesberg's, Schoeler's, and Meyer's. Landesberg enters the orbit from the inside, Schoeler from the outside, and Meyer clears a large way by dividing both straight muscles. Dr. Taylor prefers from the inside, simply because the optic nerve enters the globe to the inside of its posterior pole, and is, therefore, more readily reached from this side. I pinch up the conjunctiva immediately over the insertion of the internal rectus muscle, cut the tendon as in Graefe's operation for squint, pull the eye forwards, turn it inwards, and divide the nerve as far back in the orbit as possible; the eye is then rotated, and the piece of nerve left attached to the globe shaved off as close to the surface as possible; the cut ends of the muscle are then united by a suture, and the operation completed by the application of a compress bandage. Hemorrhage, which sometimes proves a source of trouble, may be arrested by using the now insensible eyeball as a tampon, and pushing it well back into the orbit. He has not seen a single case of suppuration from this operation, and only one of slight ulceration of the cornea, which rapidly healed. There are three principal objections to this operation: First, it is asserted that the eye projects in a ghastly fashion after enervation of the globe. Second, the globe wastes away. Third, that the nerve becomes so perfectly reunited to the globe that the patient is in the same condition after that he was in before the operation. The cases presented and the record of others prove the first objection valueless. The second is prevented by the exsection, as also applies

to the third. It is also asserted that the operation has proved fatal. No records of such a result could be found by Dr. Taylor. Yet if it should prove so in course of time we should not be surprised, for the risks of this operation are precisely those of enucleation, neither more nor less. It has been alleged that this operation has been followed by sympathetic ophthalmia of the other eye. Many among the best surgeons have recorded such an event following enucleation, and whatever follows enucleation may, of course, follow resection; the only difference between the two operations is that sympathetic ophthalmia is probably less likely to follow resection than enucleation, simply because in resection it is absolutely necessary to cut the nerve as far back in the orbit as possible, and one is thus more likely to remove the whole of the inflamed or infected portion of the nerve than in the ordinary operation of enucleation. The operations performed daily by our veterinary friends prove conclusively that if a sufficient piece of nerve is removed it never re-forms. It was formerly supposed that the channel of communication between the two eyes in sympathetic ophthalmia was through the ciliary nerves. Deutschmann's researches have conclusively shown that it is the optic nerve, its lymphatic and lymph spaces, which are alone the source of danger. Professor Schweigger of Berlin remarks: "It is not necessary to remove the exciting eyeball if by exsection of a piece of the optic nerve we can remove the bridge by which the inflammatory process travels from the injured to the uninjured eye."

The advantages of the operation are, first, that already mentioned—a less liability to be followed by sympathetic trouble. The comfort of the patient is much increased by neurectomy and that especially among laboring men, where the daily annoyance and expense is something greater than you can readily conceive. This operation is also preferable in cases of irritation from phthisis oculi, the pain being removed as well as by enucleation. These patients will often be willing to submit to this operation when they will not listen to that of enucleation. A conversation such as the following often occurs: "You had better let me remove the eye," is suggested. "Are you going to take it out?" "Yes." "Shall you put it in again?" "No." "I'll come again." Such patients never do come again.

If however you call them back and promise to restore the eyeball they will not hesitate a moment. Another advantage is that in young persons you preserve a tenant for the socket, and so prevent comparative atrophy of the orbit and that side of the face. Within the last four years I have performed this operation thirty-one times and the results have been most gratifying. Nutrition is unimpaired, motion in all directions is perfect, and indeed in some cases it is difficult to say which eye has been operated on.—*London Lancet*, Sept. 4, 1886. A. T. M.

Spalding (J. A.) on the Use of Cocaine and Passive Motion in Obstinate Cases of Paralysis of the Ocular Muscles.—Prof. S. Michel in *Zehender's klin. Monatsb.*, for Nov., '77, says our treatment of ocular paralysis is quite defective, though well versed in diagnosis. He uses the constant current with one electrode on the globe over the insertion of the affected muscle, the other on the neck, and obtains average results; treatment often extending over months, antagonistic contraction being by no means infrequent. He proposes therefore a new method, based on the principle of passive motion. The paralyzed muscle is to be grasped with forceps near the conjunctiva, and the eyeball then moved in the line of that muscle as far as possible beyond the extreme of contraction, and then back to the extreme of elongation. This motion should be continued for two minutes at each session. The pain is slight, and the irritative condition of the conjunctiva is rapidly relieved by cold compresses. The sessions should be daily. The advantages are: elimination of the action of antagonistic muscles, and diminution in length of treatment. One or two favorable results are briefly cited. Dr. Spalding tried the treatment at the time the article appeared, but his patients objected to the pain, and it was abandoned. His routine treatment of electricity, tonics, strychnia injections, and massage, yields some success. He differs with many in giving equal praise to faradism as to galvanism.

Last March finding a case of paralysis of third nerve obdurate to the usual methods, and finding no history of syphilis or rheumatism, he was led to try once more Michel's methods with the addition of cocaine, four per cent., to prevent pain. The patient was an old man; the attack had been

sudden, and been preceded years before by a similar attack. A few drops of a four-per-cent. solution were instilled into the eye, and at one session the three recti muscles were passively exercised by seizing the conjunctiva directly over their insertion, and then forcibly moving the globe in the lines of the muscles. There was no pain. No bandage was necessary, and there was no subsequent extravasation of blood to interfere with daily sessions, until at the end of one week the globe had regained extensive motion. The sessions were then reduced to semi-weekly, for another week, and one more session a week later terminated treatment. Diplopia disappeared entirely. All other treatment was discontinued on initiating this one. One other cure Dr. Spalding has had since.—*Arch. Oph.*, Dec., 1886. A. T. M.

Holt (E.)—Treatment of Detachment of the Retina.—The history of one case is given and the successful result in three others, being all the author has met. The case reported was that of a lady, sixty-four, medium height, stoutly built, had always had good health, near-sighted. In June, '84, noticed a black spot before the right eye. This grew large until in August it was a dense cloud. Examination, Oct. 18, 1884: upper half of field of vision gone. Ophthalmoscope shows the retina in lower part grayish and wavy, the summit of which is seen best with $+3$ D, while the disk is seen best with -9 D, showing a subretinal effusion of over 4 millimetres in depth. She has -8 D spherical glasses for both eyes, with which she has seen best in the right, the affected eye, for past ten years. By inclining head forwards and a little aslant vision in R E = $\frac{2}{3}$ w -5 D = $\frac{1}{3}$; L E = $\frac{1}{3}$ w -12 D = $\frac{1}{3}$. Treatment began Nov. 3d, restricting diet to simplest possible consistent with proper nourishment. A one-per-cent. solution of atropine instilled to control accommodation. Confined to two large airy rooms, but enjoined to remain most of the time in reclining position. Both eyes kept bandaged much of the time. Hypodermic injections of pilocarpine commenced with 5 minims of a two-per-cent. solution. Following day 8 minims. This caused so much nausea that infusion of jaborandi leaves was ordered so as to get one gramme at a dose. This was ordered several times a day. Hypodermic injections of pilocarpine short of nausea and free use of the infusion were

continued for twenty days, when the grayish wavy appearance of the retina had entirely gone, with restoration of field of vision and central vision equal to $\frac{1}{10}$ w — 8 D spherical. The vision further improved, and with proper glasses equalled what she enjoyed for years. March 21, 1886, the patient has still good vision.—*Am. Jour. Ophthal.*, Nov., 1886. A. T. M.

DISEASES OF WOMEN.

Scudder (C. D.) on Mollities Uteri.

—Four years ago a nulliparous patient suffering from marked antelexion of the uterus presented herself at my clinic in the Demilt Dispensary. She returned shortly after with an evident retroflexion of the organ, and in the course of the next half year this alternate antelexion and retroflexion showed itself repeatedly. The infra-vaginal part of the cervix and the body were normal, so I decided that the supra-vaginal cervix, and that portion of uterine tissue immediately above it, were in an atonic or softened condition.

The supra-vaginal cervix, and that portion of the uterus containing the internal os, will be called the middle segment of the uterus as distinguished from the cervix—that part observed by the aid of the speculum—and the body or upper third of the organ. *Mollities* suggests itself as an excellent term wherewith to designate the extraordinary softness which sometimes affects the uterus. The writer's remarks are based on a personal examination of three hundred patients.

Every one is familiar with the mollities of the cervix that appears in pregnancy.¹ If the middle segment of a pregnant uterus is carefully examined, an evident softening will frequently be detected. Mollities will also be found—rarely, however—in the body of a gravid uterus. Such uteri are so soft that the transverse diameter is often enlarged, and the antero-posterior diameter so markedly diminished that the foetus apparently lies with its length directed transversely in a soft sac, which can be moulded by the hand. Again, mollities affects the whole gravid uterus. The order of frequency in the gravid uterus seems to be mollities of the cervix, of the middle segment, of the body, and of the entire uterus.

This same softness exists as a diseased

condition in both nulliparous and multiparous women. The cervix may be very soft, the middle segment may be atonic, the body may be the site of this disease, or mollities may affect the whole uterus. The diagnosis can readily be made. A softened cervix is at once appreciated by the examining finger. A softened middle segment can be detected by raising the body of the uterus with the vaginal finger and depressing it with the abdominal hand. If mollities of the middle segment exists, the body will readily be moved without a change of axis in the cervix, showing that an exceedingly soft tissue lies between the body and the cervix. Mollities of the body is easily diagnosticated by the readiness with which it can be moulded. There is also a characteristic lack of definition in the uterine body. When the uterus, as such, is softened, definition is almost entirely lost, and the organ feels like a thick, wet dish-rag.

In point of frequency, I have found mollities of the middle segment to be most common in the nulliparous and in the multiparous non-gravid uterus; next, mollities of the fundus; then mollities of the cervix; and that of the whole uterus most infrequent.

Mollities seems to be due to the mal-nutrition of the body as such, and of the uterus in particular. Bad hygiene in the matters of exercise, ventilation, food, rest, clothing, etc., tends to produce a lack of vigor, which finds local expression in an atonic uterus. Changes in uterine nutrition induced by (a) congestions, or inflammations of the uterus, ovaries, or surrounding tissues and organs, and (b) by pregnancy, neoplasms, etc., act as potent factors in producing this condition. So that it may sometimes be secondary to uterine disease, but often a primary cause of uterine disease, when it involves either the body or the middle segment of the uterus. It seems clear to me that mollities of the middle segment, produced by systemic depression, is the starting-point of a large number of uterine and ovarian diseases.

Mollities of the cervix presents nothing of interest; that of the fundus and of the entire uterus exhibits the phenomena of sluggish circulation and complete atony; but when the middle segment is affected, a most interesting chain of phenomena, due to the results produced by this softening, will be seen. A young nulliparous woman presents herself, complains of general ill-

¹ See MEDICAL ANALECTIC, 1886, p. 42.

health and of bearing down when exercising. She has paid no attention to the laws of health, and complains of loss of appetite, costiveness, headache, fatigue on rising in the morning, general languor, etc., in addition to pelvic distress. An examination shows an atonic middle segment, and nothing else. Simple treatment is proposed and successfully carried out. Later on she may return. Cross-examination shows that proper hygiene has again been neglected. The symptoms complained of previously have returned, with addition of increased discomfort on exertion and painful menstruation on the first and second day. Conjoined manipulation now shows a well-marked antelexion with a softened middle segment. If this is not relieved by proper treatment, the flexion will become very marked. Frequent micturition and troublesome uterine dysmenorrhœa will add themselves to the other symptoms, and later on ovarian dysmenorrhœa will develop. The body of the uterus will be found enlarged and sensitive. Menorrhagia and sometimes metrorrhagia will appear. The ovaries become sensitive and subsequently enlarged.

The multiparous patient differs only in that she generally starts with a subinvolved uterus, the heavy body of which flexes itself far more readily than that of the unimpregnated uterus, if mollities of the middle segment is present. But the subjective and objective symptoms are about the same. The flexion seems to be determined by the position of the uterine axis. If this inclines backward, a retroflexion can be inaugurated by any over-exertion. If it inclines forward, an antelexion is likely to take place. Of course, if the flexions are not restored naturally, or by the aid of the physician, they will in time become fixed, and mollities will give place to a hardening of uterine tissue.

The prognosis of mollities is generally good if no exhausting disease of other vital organs is present and if hygienic regulations can be carefully observed.

Treatment must be constitutional and local. Appropriate food, proper exercise, a correct attitude, free-fitting clothing, lying quiet at least one hour a day, breathing pure air, etc., must be insisted upon in every case. Quinine, aloes, capsicum, and nux vomica have proved to be excellent uterine tonics. The bowels should be carefully regulated with fruit, vegetables,

and water. If costiveness is obstinate, the following recipe for bran biscuit will often be efficacious :

Take of bran, one quart ; flour, one pint ; milk, one pint ; mollasses, eight tablespoonfuls ; baking-soda, two teaspoonfuls. Mix. Bake as soda biscuit. One or two at each meal.

If these fail, cascara, aloes, etc., must be employed.

Flexions should be restored by digital reposition, the patient lying on her back in anterior displacements, and being placed in Sims', or preferably the genu-pectoral position, if she suffers from retroflexion. Resting ten minutes three times a day in the genu-pectoral position relieves and assists in the cure of both antelexions and retroflexions, when atony of the middle segment exists. Reposition with the Sims or Elliot repositor can readily be accomplished, and pessaries suitable to each case, or even cotton tampons, will facilitate a cure.

If the uterine tissue has become hardened, the continual pressure of an unyielding, sensitive, engorged body upon a rigid instrument will give rise to great discomfort, and sometimes positive injury. In like manner, repositors, used when mollities of the middle segment is present, are valuable ; whereas, if the uterus has been so long flexed that the atony has disappeared, the greatest skill is required to effect the desired result, and hence many regard the repositor as a dangerous instrument. Again, digital reposition has often been abandoned and set at naught because the practitioner has failed in reducing a rigid flexion after a few trials. If he recognizes mollities he can predict success by reposition. If it is absent, he knows that he has a difficult case to deal with, and can make a guarded prognosis and expect a long-continued treatment before the case can be cured.

Uterine massage will be found easy and of very great service if mollities is present. *N. Y. Med. Four.*, Dec. 18, 1886.

Sharp (L. N.) on Painful Hypertrophy of the Breast Dependent upon Uterine Disease.—"In November, 1882, I was consulted by a lady for a painful tumor of the left mamma. She came to me with the diagnosis of cancer. She was thirty years of age, the mother of three children. She was well-built and fleshy ; digestion good. The left breast was hypertrophied, the right one well developed, but

only half the size of the left. The pain in the enlarged gland was excessive and constant, and the patient said she had not had a good night's sleep for more than two years because of the painful condition. The trouble began about three years before, the breast gradually enlarging and becoming more painful. On examination I found endocervicitis and erosion. She came under treatment in December, 1882, and as the uterus returned to its healthy condition the pain of the breast declined, the hypertrophy began to lessen, and by the following June the breast was about the size of its yellow and entirely free from pain."—*N. Y. Med. Record*, Nov. 6, 1886.

Waxham (F. E.) on Occlusion of the Os Uteri as an Impediment to Labor, with a Report of Two Cases.—Mrs. S., primipara, twenty-nine years old, German, fell in labor about 9 P.M., Feb. 21, 1885. The membranes ruptured soon after the commencement of labor, and the amniotic fluid gradually drained away.

The patient was seen between 3 and 4 A.M., at which time the pains had become very severe and frequent. Upon examination the head was found low down in the inferior strait, almost presenting at the vulva, and covered apparently by a thin membrane through which the advancing head threatened to burst with every pain. Upon the most careful digital examination no os could be discovered, nor the slightest indication of one. Dr. Nelson was summoned and promptly responded. His more experienced finger detected a very slight dimple in the centre of the presenting tissues. By keeping the finger upon this slightly thickened tissue he discovered that it became very much thinner with every pain, while as the pain subsided the tissues assumed a very slightly umbilicated appearance. By firm and continued pressure upon this suspicious spot an opening was at length effected and the os gradually dilated. As the labor proceeded slowly, and fearing the result to the child of so long a delay of the head in the pelvis, and the os being fully dilated, the forceps were applied. The child was delivered without injury to the mother, but it was asphyxiated and required considerable effort in resuscitation. Dr. Nelson stated that this was the second case that had ever come under his observation, and kindly gave me the history of the following one: He was called to attend a lady in her first confinement, a

Swede, twenty-three years old, and married about one year. Making a hasty examination, he found a well-formed cervix, but did not detect the os. On returning a few hours later, the head had descended to the inferior strait and was, indeed, presenting at the vulva and covered by the cervix, which had become so thin as to resemble the membranes. The membranes had already ruptured and the amniotic fluid had gradually escaped. There was no appearance whatever of the os. It could not be detected with the finger, and the head seemed about to burst through the uterine tissue. The patient was placed before a window the labia separated, and careful search made for the os. Only after a most careful search was it found. It was patulous only to the extent of admitting the very finest surgeon's probe. After this had been introduced and worked about, a second probe was passed, and by separating them the os was gradually and sufficiently dilated to allow the finger to enter. The os was then rapidly dilated, and labor progressed normally—*Am. Jour. of Obstetrics*, Sept., 1886.

Baer (B. F.) on Fibroid Tumor Which Had Undergone Calcareous Degeneration.—Mrs. L., æt. sixty years, a patient of Dr. J. H. Musser, of Lancaster County, Pa., has had two children and two miscarriages. She had been treated for uterine hemorrhage a number of times during the last fifteen years. She continued to "menstruate" until she was fifty-seven years of age. One year afterwards she began to suffer from severe uterine trouble, which was soon followed by a severe attack of "flooding." After this she had frequent recurrence of the hemorrhages up to the time of the removal of the cause. I saw the lady at her home in September, 1885. She had a marked cachectic appearance, and there was an odor very like that of cancer. I advised that a thorough investigation be made with the patient under ether. I found the cervix smooth and soft; the os slightly patulous, and there were several mucous polypi hanging from it. There was also a fetid muco-purulent discharge, which seemed to come from the cavity of the uterus. I removed the polypi, and then carefully passed the sound into the uterine cavity; it was large and filled with numerous soft bodies, vegetations, except at one point, at the fundus. Here a mass was detected which was as hard as

marble and gritty. I next dilated the cervix with my steel dilator, which was easily done, because the tissues were so soft and dilatable, and passed my finger into the cavity. The finger confirmed what the sound had led me to infer. I now removed with the dull curette all of the fungus vegetations (enough to fill a large spoon in the aggregate), and then again introduced my finger and found that the hard mass was imbedded in the uterine wall and pedunculated. I endeavored to remove it with my finger, but failed; I then pried it out of its nest with one blade of a polypus forceps. It proved to be a fibroid tumor which had undergone calcareous degeneration. I cauterized the entire surface of the uterine cavity with fuming nitric acid. The patient has had no hemorrhage since.—*Obstet. Gaz.*, Jan., 1886.

Meade on Pregnancy with Almost Imperforate Hymen.—On March 15, 1886, I saw a young married woman in consultation, who was threatened with symptoms of premature labor, and in whom the medical man in attendance could not find the os uteri. I first satisfied myself that she was pregnant (apparently about six months, from size of abdomen) by hearing the foetal heart. I next ascertained by the finger in the rectum that there was a proper sized cervix uteri. On attempting to pass my finger into the vagina I found that there was a fossa or depression an inch or an inch and a-half deep, but nothing else in the shape of a vagina. In this depression I could feel the orifice of the urethra some way down, through which I passed a silver catheter into the bladder. I next carefully explored the bottom and sides of this pouch, which had evidently been made by imperfect attempts at intercourse, and after a little trouble passed the extremity of a uterine sound into a small hole, when it at once went freely up to the uterus. After withdrawing the sound, I easily felt the aperture with the point of my finger, and found that it was seated in the middle of the hymen, which had been pushed inwards and displaced by the attempts at coitus. I forced my finger through the aperture, easily tearing the membrane, and then passing it on found quite a capacious vagina and natural cervix and os uteri.—*Med. Press and Circ.*, Dec. 8, 1886.

Gaston (J. Mc F.) on Medicated Applications to Os Uteri in Vomiting

of Pregnancy.—My method consists in painting over the os uteri with the following mixture: iodine, carbolic acid, and tannin, each, one drachm, dissolved by heat in four drachms of glycerine. After this application is made, a pledget of cotton-soaked in glycerine is placed over the surface, and outside of this a tampon of dry cotton is deposited in the vagina, so as to keep it in its place.

I have had three extreme cases in the course of this year in which it has been applied with satisfactory results; and not having used it in the milder or more tractable cases of vomiting, my limited experience confirms all that has been claimed for this treatment. In two of my cases a great variety of internal remedies had been employed by other medical attendants, and in the third under my own care such corrections as I have generally found beneficial, were all found useless—when the above application was attended with prompt relief. In one patient the compound was applied with a camel's-hair pencil on two consecutive days, whereupon the vomiting ceased, and no repetition was required. In another two applications with an interval of three days sufficed. And in the third it was applied but once.—*So. California Pract.*, Nov. 1886.

Parker (W. T.) on the Oakum Pessary.—At a meeting of the New York Obstetrical Society held November 5, 1878, I reported the excellent results which followed the use of the oakum or marine-lint pessary. Marine lint or refined oakum is a surgical dressing of great value, and it was only after witnessing the success attending its use in surgery, that it occurred to me that it might be useful in gynecology.

For prolapsed and sensitive ovaries, for the treatment of prolapsed uterus, for many forms of misplacement, and in cases of leucorrhœa, marine lint is much preferable to absorbent cotton, and keeps sweeter and cleaner longer than any other appliance. The support it affords and the sense of comfort it induces, make it very acceptable to patients. I apply it always in a ring form, introducing it through the speculum. Where a large pessary is indicated, as in prolapsed uterus, it must be introduced without the speculum. The oakum never irritates and is always free from the odor following the use of any other pessary or of absorbent cotton. The oakum pessary not only absorbs and disin-

fects the vaginal secretions, but does not lose its place, and continues to afford support until removed. In cases of anteversion or retroversion as well as in cases of prolapse, the oakum pessary will be found superior to the hard or soft rubber pessary. The oakum is not only an excellent support, but possesses healing properties when applied to the diseased mucous membrane of the vagina.—*New Eng. Med. Mo.*, Nov. 15, 1886.

Dill on Labial Hæmatoma.—The patient was a primipara, aged twenty-one, and her labor had been completed without artificial aid. Shortly after delivery her medical attendant noticed a rapidly growing tumor in the right labium. This tumor, when seen an hour subsequently, had attained a size somewhat larger than that of a large foetal head. On the internal surface of the tumor—*i.e.*, within the vulva—the finger came upon a thin membranous covering which immediately ruptured, exposing a huge cavity filled with a quantity of clotted blood. After removal of the clots the cavity was filled with pledgets of lint soaked in carbolic solution, and the whole made as secure and comfortable as possible. No further hemorrhage resulted, and the patient gradually rallied from the shock, which had been very severe. The ecchymosis resulting from this hæmatoma, extended round the buttocks, and as far down the right thigh as the knee; it also spread over the abdomen on both sides as high as the level of the umbilicus, and on the right side almost into the axilla. Frequent changes of dressings were required at first, and considerable comfort afforded by hot stupes and poultices. Hot antiseptic irrigations were employed twice daily at first, and the patient rapidly gained ground after the first fortnight, being finally completely restored to health.—*Dublin Four. Med. Sci.*, Nov., 1886.

Oliver (J.) on Inflammation of the Mucous Lining of the Fallopian Tube, with Puro-Fibrinous Exudation.—At a late period, when fluid has begun to accumulate in and distend the tube, and inflammatory changes are apt to invade the surrounding structures, symptoms of a definite and truly characteristic nature invariably develop.

Pain is a constant and troublesome symptom. Its seat and character, however, vary according to the extent and manner in which the pelvic nerves severally become

involved. It is more or less constant or periodic, and is usually referred to that iliac region in which the diseased condition is to be detected. If both Fallopian tubes are the seat of change, as is commonly the case when the disease is due to specific inflammatory extension, pain is complained of in the neighborhood of both groins. In many cases, the attacks of pain are periodic, lasting six or seven days, with an interval of immunity of like duration. The onset of the recurrence is generally accompanied by a feeling of faintness. The pain, as a rule, is materially altered by position, the patient experiencing relief and a feeling of comfort when lying on the affected side. It is aggravated by the upright posture and by locomotion; and a dragging sensation is often developed when the patient is lying on the opposite side to that on which the disease exists. Sometimes there is backache; occasionally there are sharp cutting pains in the vagina; usually there are radiating pains referred to the inside or outside of the thigh—as far as the knee—corresponding with the side on which the change in the Fallopian has arisen. Menorrhagia is the symptom, however, which is most likely to attract special attention; but, depending as it does upon an interference with the nerve-supply to the uterus, it seldom appears until the distension of the Fallopian tube has become marked, and the condition unmistakable. The hemorrhage, as a rule, when once established, is more or less constant. Considering the close proximity of the pelvic viscera to each other, and the manner in which each derives its nerve-supply, it is not to be wondered at that change arising in one of these organs is more or less likely to affect and influence the functions of the others. In pyosalpingitis, there is usually a frequent desire to pass urine; but during the time of hemorrhage, the patient is likely to experience a difficulty in emptying the bladder, it being essential to strain much, and call into action those volitional muscles which may aid in the performance of the act. In some cases, there may even be complete retention of urine. It is but seldom that pain is complained of during the time of voiding urine; but, should the patient be obliged to retain the urine longer than usual, so that the bladder becomes somewhat distended, pain will be felt in the region of the diseased tube. Sometimes there is

diarrhœa ; occasionally there is pain before voiding motions, more especially if the rectum be loaded, and the disease exist in the left Fallopian tube, which may, by inflammatory adhesions, have become closely attached to the lower bowel. In a few cases, stiffness of the thighs is to be noted. In those cases in which there is frequent desire to pass urine, cold aggravates the condition.—*Brit. Med. Jour.*, Jan. 9, 1886.

A Discussion on Transient Elevations of Temperature after Delivery, and the Indications for a Resort to the Intra-uterine Douche.—Dr. Hanks opened the discussion. He considered it very difficult to tell, within the first twelve hours after delivery, whether a rise of temperature was due to septic or malarial influence. If, on careful examination of the genital tract, he found a laceration of the cervix or perineum, or an œdematous state of the vagina around the cervix, he was inclined to attribute the rise of temperature to the absorption of septic matter. In case the uterus was large, and the lochia fetid, he resorted to the douche.

Dr. Rodenstein stated that a chill coming on suddenly and followed by sweating was apt to mean malaria. A strong point in differential diagnosis he considered to be the state of the external os. In sepsis, he had noticed that the os was always patent ; in malaria, usually closed.

Dr. Patridge stated that the pelvic organs should be carefully and thoroughly examined, not alone once, but repeatedly, for frequently the second or third examination would reveal a cause not appreciable on the first. If, finally, he could find no cause for sepsis, he then concluded he was dealing with malaria. When we remembered how much constitutional disturbance might result from a simple abrasion on the surgeon's finger, it was amply evident how a slight lesion of the cervix, for instance, might be overlooked, and yet be at the bottom of septic infection.

Dr. Murray had never seen a case in which careful examination would not reveal some cause for the elevation of temperature, aside from malaria. He pleaded for careful examination of the genitals, both external and internal, and recalled the fact that a patient might have a large plastic exudation without much febrile disturbance, and yet this be entirely overlooked if a vaginal examination was not made. He had no-

ticed the fact that in every case of sepsis the external os was patent, but he believed that the prime differential point between malaria and sepsis lay in the fact that in the latter there was never complete remission in the temperature, and that generally there were two exacerbations daily. The constitutional depression also was greater in sepsis than in malaria.

Dr. Mundé stated that it was his habit to assume rise of temperature after delivery as probably due to septic absorption. Patency of the external os to him signified something within the uterus—remnant of placenta, or decomposed clot. He had recently seen a case in a pronounced malarial neighborhood, where the patient's temperature was 104°, the pulse 130, the facies bad, the lochia very offensive, the uterus large, the os admitting three fingers. With his long curette he had removed a mass of offensive blood clot at the placental site, washed out the uterus, and given antipyrine and applied the ice-coil. The temperature was lowered, but for three days there had since occurred chills and rise in temperature, which he was now inclined to believe were due to malaria. Malaria, he was well aware, was a hobby with some gentlemen, as was evident in a case he had recorded a few years ago, where one of his consultants clung to the diagnosis of malaria in the face of a metastatic abscess on the wrist. This case he had considered pure septic pyæmia. He was convinced that peri-uterine exudations were often overlooked, for the simple reason that careful vaginal examinations were not resorted to. These were, of course, the very cases where intra-uterine irrigations would be productive of harm instead of good.—*Am. Jour. of Obstetrics*, etc., Nov., 1886.

Duke (A.) on the Advantages of Abdominal Support during Pregnancy.—I always advise patients in a pregnant condition to leave off their corsets (from about the fourth month onward, should I see them at that time), and having supplied the want of a corset by a suitable bodice, to wear a supporting belt with elastic sides, so arranged as to exercise a comfortable pressure, from *below*, on the muscles, and fitted with tapes or straps to relax the pressure as the uterus enlarges. In every case in which I have recommended this to be done, and where my directions were followed, the patient not only ex-

pressed herself as feeling far more comfortable, but I have remarked that the subsequent labor was of much shorter duration than usual, owing, I believe, to the support afforded in time to the abdominal muscles, and which, by husbanding their tone and strength, enabled them to assist the uterus, in its efforts of expulsion, in a marked degree.

When engaged to attend primiparæ, I also direct the bandage to be left off at night, and the abdomen well rubbed with lard at bedtime. When this treatment is followed in primiparæ, I find there is little or no trace of the "linea albicantia" to be discovered after the patient recovers from the lying-in, and the abdomen also resumes its natural appearance, which the patient as a rule is the first to remark.—*Provincial Med. Jour.*, Dec. 1, 1886.

Draper on Extraordinary Cardiac Excitement before a First Menstruation.—Dr. Draper reported the following case before the Obstetrical Society of Boston: The patient was an overgrown, nervous, well-developed girl, aged thirteen years and two months. Two years ago she was under medical treatment for chorea. During the past three years she had not attended school. Recently, her health had been satisfactory, and it was the intention that she should presently resume school discipline. Her mind was undeveloped and her tastes were childish; she liked the plays and companionship of little girls much younger than herself. She had never menstruated.

In the night of July 1st, she was restless and uneasy, sleeping but little. Her mother attributed the unrest to a somewhat later and heartier supper than she was accustomed to and recalled also that the girl exercised rather more vigorously than usual after supper. Dr. Draper saw the patient at 3:30 A.M., July 2d. She was tossing, restless, anxious, and irritable. She complained of pain in her left side and of the "thumping" of her heart. There was an occasional short, dry cough, —the familiar cough of cardiac palpitation. The hand over the heart detected a rapid but regular and not violent action of that organ. The stethoscope discovered no abnormal sounds; the rapid action was the only abnormality. There was no irregularity or intermission, then or later. The heart-beats, at this visit and subsequently, were counted as follows:

July 2d, 3:30 A.M. . . 212	July 4th, 9:30 A.M. . . 234
" 2d, 7:30 P.M. . . 232	" 4th, 5:15 P.M. . . 230
" 3d, 10 A.M. . . 228	" 5th, A.M. . . 98
" 3d, 5:30 P.M. . . 236	" 6th, A.M. . . 80

The highest temperature which the thermometer recorded meanwhile was 100.5°, in the afternoon of July 2d.

The culmination of the case was reached July 5th, in the afternoon of which day menstruation began in a perfectly normal manner, without pain or other disorder. The pulse quickly regained its normal rate and kept it thenceforward. In August and September there was no recurrence, either of the catamenia or of cardiac disturbance.

During the three days, July 2d, 3d, and 4th, various measures directed to the control of the heart were wholly negative in their effect. Rest in bed, low diet, counter-irritants, emetics, cardiac sedatives and stimulants (aconite, veratrum, digitalis), proved unavailing; but with the premonitory indications of the menstrual function the heart resumed its natural action.—*Boston Med. and Surg. Jour.*, Dec. 9, 1886.

Hale on the Relations of the Heart and Reproductive Organs in Women.

—Previous to puberty little or no sympathy exists between these organs, but towards that period there springs up a wonderful interdependence. It is at this period that the heart begins to beat with new force and frequency, and becomes far more sensitive to influences from within and without than before. Palpitation is apt to occur from slight causes and uncalled-for attacks of localized hyperæmia, as exemplified in blushing. Girls rarely blush before the age of puberty, and the age of true blushing declines after puberty is established. It occurs again during pregnancy, and also at the change of life, for at these epochs the heart is enlarged and its nervous system becomes hypersensitive. At this age he often had patients sent to him supposed to be suffering from heart-disease, and complaining of palpitation, irregular action of the heart, and precordial distress. Medicines were of little avail in such cases. The cardiac trouble in such patients is generally physiological—that is to say, due to influences transmitted to it by the developing reproductive organs. Unless occurring in scrofulous or rheumatic subjects, little medical treatment is called for, the physical habits alone requiring to be regulated. Undue exercise should be forbidden, and the emotional nature should be

restrained. Late hours and the too promiscuous mingling of the sexes at balls, etc., should be avoided. If not, a genuine cardiac affection may result. Occasionally a displacement of the womb, a flexion, or a congested or abraded cervix will give rise to cardiac disturbances of great intensity. Ovarian irritation of various kinds has the same effect. It is important, therefore, to eliminate any such source of trouble. The next great epoch in a woman's life, wherein is found a reflex irritability of the heart from the reproductive organs, is during pregnancy. Many women are made aware of conception having taken place by a peculiar action of the heart. All through the period of gestation, palpitation, flushing, and blushing, etc., are observed. The enlargement of the uterus and the necessity of carrying on a greatly increased circulation in its walls during pregnancy are attended by a temporary hypertrophy of the heart, mainly affecting the left ventricle. After delivery the heart soon returns to its normal standard. Care in diet, exercise, and dress, is therefore necessary during pregnancy, in order to avoid any trouble from this source.—*From Archives of Gynecology*, Aug., 1886, in *Lond. Med. Record*, Dec. 15, 1886.

Post-Partum Troubles in American Women—Too Much Gynecology One Cause.—Our girls certainly suffer from too much in-door life, but I think this is being very rapidly corrected, and out-of-door games and occupations are becoming more and more popular.

The greatest danger our girls and young women have nowadays to encounter is the amateur gynecologist. As soon as a physician possesses a brass-mounted table and a speculum and a pair of forceps, he is recognized at once as making a *specialty* of gynecology, and the number of congestions, ulcerations, flexions, versions, and heaven knows what all, that afflicts our young girls from sixteen years upward is simply awful! No, the girls are all right, but the gynecologist is all *examinations*. Give our women a reasonable rest, and spare the dreadful nickel-plated speculum, and our women will be healthier and happier, and there will be less to complain of concerning post-partum troubles in American women. The poor uterus, punched, pricked, soaked with iodine, or blistered with nitrate of silver and all the other applications, not to speak of the legion of pessaries which are

introduced, for no good reason, is enough to make any woman weak and liable to post-partum troubles, even if such abuse does not make them sterile.

For young girls of sixteen to be subjected to the examination with a speculum, or for girls of nineteen to be obliged to carry about a pessary big enough for a multipara, is certainly not very desirable, and reflects little credit upon the amateur gynecologists who carry out such meddling theories. Gynecology is useful, and oftentimes indispensable; but every candid physician must admit that we have at present in full operation all the gynecologists we shall need for twenty-five years to come. There are other departments of medicine much worse off, as regards numbers, than gynecology, and the advice of the old physician to the younger when asked if an examination should be made, when he replied, "Don't," is good advice in a large number of gynecological cases to-day.—*Letter to N. Y. Medical Record*, Dec. 4, 1886.

PATHOLOGY.

Barling (G.) on Necropsy of a Case of Myxœdema.—A clinical note of the case has been reported by Dr. Suckling in *The Lancet* of May 15, 1886.¹

The necropsy was made thirty-six hours after death. External appearances: The body of a very stout old woman; the lower lip much everted and swollen; cheeks of a bright-red color; a well-marked arcus senilis. The legs, face, and arms pitted on pressure, but no fluid could be made out in the abdomen. Incision into the tissues did not reveal the mucoid appearance mentioned in other cases. The cranial bones were very thick, especially in front, there reaching to nearly a third of an inch. The brain and its membranes presented no abnormal appearance. Weight of brain two pounds, ten ounces. The pituitary body was reserved for microscopical examination, but no change was subsequently found in it. The cervical sympathetic showed no change to the naked eye, but it was not examined with the microscope. The thyroid body was small, especially the right lobe, and it was very tough to the feel, and so intimately blended with the cervical fascia that it was difficult to sepa-

¹ See *MEDICAL ANALECTIC* for June, 1886, p. 273.

rate the two exactly. The weight of the organ was 155 grains. Microscopic examination showed a simple atrophy of the gland structure in some places complete, in others only slightly advanced. If a fairly plump lobule were examined, it showed at its periphery the remnants of atrophying capillaries; next to this a zone in which the capillaries had not undergone marked change, but the meshwork formed by them, enclosing the alveoli, had lost its epithelial lining, as well as the colloid material found inside. In the centre of the lobule, capillaries, epithelium, and colloid material appeared in the relative proportions found in health. There was nothing to indicate that the disappearance of gland tissue was due to a formation of granulation tissue resulting in a cirrhosis. The submaxillary glands weighed one ounce. No abnormal condition was found in them either by the unaided eye or with the microscope. The lungs were crepitant throughout, and presented a few caseous and calcified nodules scattered sparsely through them. The heart weighed fourteen ounces, and there was marked hypertrophy of the left ventricle. The valves were fairly healthy, but there was considerable atheroma of the aorta. On opening the abdomen several ounces of glairy but clear fluid were found. Some of this collected and boiled became practically solid in the test-tube. The liver was adherent to the stomach, its capsule was much thickened, and microscopic examination showed a slight cirrhosis in places advancing from the surface. The gall-bladder was distended with about four ounces of pus, the cystic duct being plugged with a calculus which was solitary. The kidneys weighed ten ounces; the capsule was thickened and adherent, and the cortex rather narrow. Microscopic examination showed a moderate amount of interstitial nephritis. The spleen was firm and dark, and weighed three ounces.—*Lancet*, Nov. 20, 1886.

Young (G. H.) on Extensive Contraction of the Ileum as a Sequel of Enteric Fever; with remarks.¹—On March 29, 1885, I was asked to see Mr. G. W., a civil engineer, æt. 23. He had always enjoyed good health until two and a half years ago. At that time, while stationed at Kurrachi, he had suffered from a

very severe attack of enteric fever. Several relapses had occurred, and the disease lasted about two months before convalescence was established. From that time up to the present date his health had been good. He had not since suffered from indigestion, constipation, or abdominal pain, or uneasiness of any kind.

On the morning of March 28th he had been out pig-sticking, and while riding over some very rough ground his horse had stumbled. He felt a sudden jar, followed by pain, in the right iliac region. After this he rode home a distance of seven miles. He stated that his bowels have been quite regular up to two days before, but since then they had not acted. On returning from pig-sticking he had taken a large dose of castor-oil. This caused violent vomiting and greatly increased pain in the iliac region.

When I saw him his pulse was frequent and small. The temp. was 100 deg. The tongue was slightly furred. He had frequent bilious vomiting. He complained of constant dull pain in the right iliac fossa, with occasional acute exacerbations. On physical examination the abdomen was found considerably distended. There was a feeling of tension over the iliac fossa, and the patient complained of great tenderness. Over the seat of tenderness, which was on a level with the superior spinous process of the ileum, and about two inches internal to it, there was slight loss of resonance on percussion. Immediately above this, percussion produced a note exactly similar to that heard over the stomach. The gums were very swollen and spongy, showing a marked scorbutic taint.

The case was diagnosed as one of typhlitis. Opium, gr. j. every third hour, was ordered. His diet, consisting of milk and beef-tea, was given frequently in small quantities. Warm fomentations and poultices and extract of belladonna were applied over the iliac region. After this treatment had been continued for forty-eight hours all the symptoms disappeared, and I determined to give him an enema. An O'Byrne's tube was passed to its full length, and a quart of linseed-oil, with which was mixed pulv. ipecac., 3 j, was injected. This only brought away a few hard scybalæ, which evidently only came from the large intestine. That evening I repeated the same enema. This time it had the desired effect, and he passed an

¹ This communication is of such extreme interest that it is quoted nearly entire.—Ed.

enormous quantity of fæces. He expressed himself greatly relieved, and for two days every thing went well. The bowels acted regularly. The diet was still restricted to milk and beef-tea.

On April 3d, diarrhœa set in and feverish symptoms developed themselves. The tongue became of a bright red color, and there was intense thirst. The bowels were moved from two to six times in the twenty-four hours. The motions were of a bright mustard color, exactly like those one often sees in tropical enteric fever. There was diffused abdominal tenderness, most marked over the right iliac region. There was also gurgling on pressure over the right iliac fossa, and well-marked tympanitis. The temperature varied from about 100 deg. in the morning to 101 deg. in the evening.

The symptoms clearly suggested enteric fever. Opposed to such a diagnosis, however, was the fact that he had had a previous severe attack of that disease; that there was no rash; no enlargement of the spleen; no lung complication; and that the temperature never exceeded 101 deg. After a careful consideration of the case I came to the conclusion that there was intestinal ulceration, probably caused by the previous retention of hardened fæces; and further that there was subacute peritonitis, probably tubercular in its origin.

From the first the symptoms were of a very adynamic type, requiring free support. The diet, which consisted of milk and beef peptones, was given regularly every third hour. Champagne was given at regular intervals. The diarrhœa and intestinal irritation were relieved by the free use of opium, and the tympanitis by turpentine fomentations. Quinine, ammonia, and bark were also given. In spite of all treatment the adynamia increased, constant vomiting set in, and he died on April 15th with all the symptoms of perforation of the intestines.

Post-mortem.—On opening the abdomen the intestines were found greatly congested and of a deep prune color, and at first sight it appears as if there were two stomachs. On closer examination the lower twenty-two inches of the ileum were found greatly contracted. The contraction was so great that the first joint of the thumb was with difficulty inserted into this part of the intestine. At about two inches above the ilio-cæcal valve, and again near the upper part of the constriction, was a firm

band of fibrous tissue. Both these bands appeared to have been developed in the sub-mucous tissue. Through these constrictions only the tip of the little finger could be passed. Immediately above the constriction, for about fifteen inches, the small intestine was enormously dilated. In size and shape, this dilatation closely resembled the natural stomach. It had pushed the cæcum and ascending colon backwards, and completely concealed them from view. The muscular coat of this enlarged portion was enormously hypertrophied. Over the surface of both the contracted and dilated parts of the intestine there was a considerable quantity of recently effused lymph, but no old adhesions or bands could be found. All the remaining parts of the small intestine were dilated to about twice their natural size.

On removing the intestines, and opening the contracted part, its inner surface was found covered with old cicatrices of typhoid ulcers. These had a contracted, puckered look. So extensive were the cicatrices that at one time almost the entire mucous membrane of this part of the intestine must have been destroyed. In several places, also, the muscular coat appeared to have been destroyed. Four recent ulcers were found in the narrowed parts of the bowel. These had none of the appearances of typhoid ulcers. They were not situated opposite the attachment of the mesentery; they were circular in shape with jagged edges; they occupied the sites of old typhoid ulcers; and they were covered with dark gangrenous-looking sloughs. Neither had they the irregular outline and thickened indurated edges of tubercular ulceration. The ulcer nearest the ilio-cæcal valve had given way leaving an opening as large as a threepenny piece. In the remainder of the small intestine the mucous membrane was congested, but was otherwise healthy. The coats of the large intestines were thickened and opaque. In the caput cæci was a second perforation about as large as the first. A quantity of reddish serum was found in the peritoneal cavity, but there were no signs of tubercle. Neither the spleen nor the mesenteric glands were enlarged. All the other organs were healthy.

In describing cicatrization of a typhoid ulcer, the late Dr. Murchison says: "It is never surrounded by any puckering, and it never causes any diminution in the calibre

of the g. t." It must be a rare sequel indeed when such men as Corrigan, Hudson, Murchison, Jenner, etc., have never met it. The extent of the contraction in this case was surprising. That it was the result of enteric fever could not be doubted. The presence of the contracted cicatrices, and the absence of any external adhesions or bands, sufficiently proved this. That the contraction had existed for a long time, and had been very gradual in its onset, was shown by the enormous dilation and hypertrophy of the gut above it. That such marked changes should have existed for such a long time without producing any symptoms is not the least curious point about the case. I believe the following is what took place in this case: There had been a gradual accumulation of feces in the dilated part of the intestine. The sudden jar forced some of the hardened mass into the upper part of the constriction, and complete obstruction was the result. The subsequent ulceration was in all probability due to the injury done to the weaker of the cicatrices by the hardened feces as these were forced onwards. The marked scorbutic taint would greatly increase the tendency to ulceration. Another point of interest in this case is that it shows that simple ulceration of the intestines may light up a train of symptoms closely resembling those of enteric fever.

The ipecacuanha was added to the enemata, as I have found this addition of the greatest use in cases where obstinate constipation existed. I gave beef peptones in this case, as I have found them invaluable in the dieting of cases of tropical diarrhoea and enteric fever. They are more easily assimilated than any other form of nourishment, and they never increase the diarrhoea by irritating the bowels, as ordinary beef-tea is so liable to do.—*Medical Press and Circ.*, Dec. 1, 1886.

Lewis (M. J.) on a Partial Study of the Seasonal Relations of Chorea and Rheumatism.—The author has studied this subject by means of a comparison of curves of barometric pressure, humidity, and the prevalence of the two above-named diseases. He says:

While the chorea tracing shows a strong tendency to keep pace, month by month, with the irregularities of the storm tracing, that of rheumatism, while also strongly resembling the latter, may be seen to be exactly *one month later*, looking as if

the effect of the meteorological changes was immediate in the case of chorea (as it is now acknowledged to be in some varieties of neuralgia), and preparatory only in the case of rheumatism.

From the close relationship known to exist between these two diseases, one might be led to suppose that the rheumatism tracing would precede, or at least accompany, that of chorea, instead of following it, as this study seems to show.

Of attacks of chorea, the greatest number appear in March, while of attacks of rheumatism, the greatest number commence in April.—*Med. News*, Nov. 13, 1886.

Murray on the Barometer as a Guide to Health.—In the *Lancet*, April, 1886, p. 761, Dr. Wm. Murray writes that for many years he has noticed the effect of atmospheric pressure in the causation of cerebral and other hemorrhages and convulsions in children; during periods of great electrical disturbances and sudden and extreme fluctuations of the barometer, these cases are much more common. On March 1, 1880, the author was summoned to two patients who had been seized with cerebral hemorrhage within a few seconds of one another. The barometer at the time was standing at 28.10°. Again, on April 7, 1886, the barometer sank to 28.4° in the evening, and remained at that point until the next day. On the evening of the 7th, the author was summoned to a case of convulsions in a child, and to two cases of uterine hemorrhage, ending in abortion in the early months of pregnancy. On the same evening, in Dundee, three cases of sudden death were reported within a radius of twelve miles. Some observations have lately been made by Dr. Veeder, of New York, on the occurrence of deaths from apoplexy at times when rapid fluctuations of the atmospheric pressure were indicated by the barometer. It is suggested that these cases are due to a difficulty in the adjustment of the volume and rate of the circulation of the blood to the varying atmospheric pressure upon the surface of the body, thus causing an unusual strain on weakened vessels.—*London Med. Record*, June 15, 1886.

Stedman (T. L.) on the Influence of Maternal Impression in the Etiology of Congenital Deformities.—I believe that the mental impressions of the mother oftentimes react, for good or for

bad, upon the growing form of the child in her womb. A violent nervous shock is liable to cause the death or arrest of development of the embryo; a less severe, but more prolonged, mental impression may occasion a perversion of development. In the first case, if the child live, it will be a monstrosity; in the second case, it will be simply deformed in some part, and the peculiar nature of the deformity, or the part affected, will be determined by the nature of the mental process on the part of the mother. The concentration of her thoughts upon some particular anatomical portion may cause that portion of the child to assume the shape corresponding to the appearance that exists in the mother's mind. In the first case, the blood is so altered as to be actually poisonous to the growing embryo. In the second case, it is the medium for transmitting nervous actions from the mother to the child; and that child's nervous system is then placed in a condition similar to that of an hysterical woman, in whom a particular part of the body may become deformed or the seat of inflammatory changes from purely nervous causes.—*N. Y. Med. Rec.*, Jan. 1, 1887.

Hall (J. L.) on Congenital Encephalocele.—Mrs. K., white, aged forty-five, multipara, mother of fourteen children, wife of a farmer, has given birth to twins twice. She was taken in labor on the morning of November 21, 1886. On our arrival we found that the child had been delivered. The case had been one of face presentation, and the child was fully developed, with the exception of a deficiency of at least two thirds of the frontal bone, with an encephalocele protruding. The tumor was the cause of the failure of diagnosis. The child measured about eighteen inches in length, and weighed ten pounds; it lived about twenty hours, dying in convulsions, which commenced about ten hours before death.

This is a case wherein maternal impressions are claimed to be the cause of the deformity. The mother alleges that she killed a snake about the time of conception by mashing its head.—*Am. Pract. and News*, Dec. 25, 1886.

Cooper (W. F.) on a Monstrosity.—The left arm was entirely absent, and the patella and tibia of left leg wanting. The right side, unlike the left, supported a good leg, but the forearm had but one bone, the radial, and no thumb.

The entire weight of the child was but three and a half pounds, yet at the time of writing, nine days after its birth, it is alive and doing well.

I may mention that the cord was unusually short—ten inches,—and at the time I made my first examination it was found prolapsed, but the labor was so rapid as to render its return both useless and impracticable.—*Miss. Valley Med. Mo.*, Oct. 10, 1886.

An Arterial Anomaly.—There was, last week, in a subject in the dissecting-room of the Ledwich School of Medicine, Dublin, an example of a comparatively rare anomaly. The right subclavian artery came off from the arch of the aorta, and the right common carotid also took its origin from the arch. Practically there was no arteria innominata. The two carotids at their origin were barely separated. Excluding the coronary arteries, there were four branches from the arch of the aorta.—*Lancet*, Nov. 6, 1886.

Purser on a Liver with Two Gall-Bladders.—The specimen was of some little interest from its rarity, though not exemplifying any great morphological law. It was taken from a girl aged eleven years, who was admitted into Sir Patrick Dun's Hospital extremely ill of scarlatina, which she had had for five days, and who died a few hours after her admission.—*Lancet*, Dec. 4, 1886.

Inglis (J. A.) on a Deficiency of the Lumbar Vertebrae.—Was called November 29th, P.M., to see Mrs. K., who was then in labor. Upon examining the child I found it a nice, hearty, well-featured, and well-developed female child, excepting a deficiency of three lumbar vertebrae, there being no connection with the lumbar vertebrae and the sacrum. The space was occupied by a very thin and transparent membrane. A portion of either kidney was discernible through this membrane. It did not appear to be painful. The afternoon of the second day there was a collection of semi-transparent fluid under this thin membrane. The third day it was more of a muco-purulent character, with indications that pus might soon form. Matters thus progressed to the tenth day, when death came to its relief. Unfortunately, no post-mortem was obtained.

From the first the child had no use of its lower limbs. The bowels and kidneys were normal in action. It nursed well, and

slept most of the time. It could not lie on its back without distressing it.—*Med. and Surg. Reporter*, Jan. 15, 1887.

Keser on Intra-Peritoneal Hemorrhage in a New-born Child.—The child was born on April 29th, at full time, after a normal labor, the *liquor amnii* being very abundant, and containing some meconium. The child required stimulation before respiration was established. The next day the child lost a few drops of blood from the nose, and a small ecchymosis was found under the conjunctiva of the right eye. The left half of the scrotum was slightly swollen, and had a bluish tinge. The child took the breast well, and did not seem to be suffering. On May 1st the scrotal swelling increased, and the penis was œdematous. The bowels acted well, and plenty of urine was passed. On May 4th the scrotum was much swollen, and formed a bi-lobed tumor as large as a walnut; no pulsation could be detected. Small ecchymosis on right side of the abdomen, and the alveolus of the left central incisor of the upper jaw was distended with blood. The child had passed a yellowish motion, and had taken the breast well. Temperature 98°. Abdomen somewhat distended, and the lips were pale. May 6th.—The child was very pale and weak, and another ecchymosis had formed in the middle of the back. The abdomen was more swollen, and there was some dulness in the flanks. No sickness. On the following day the lower part of the abdomen was much swollen, and was of a greenish tinge. The child died the same evening. At the post-mortem examination, on opening the peritoneal cavity, about eight ounces of fluid blood escaped. No sign of peritonitis, and the intestines were healthy. The spleen measured 9 cm. in length, the normal length being 3 or 4 cm. The upper half was swollen and of a dark color; the lower half was pale, and the limit between the two was very distinct.

There was no history of hæmophilia or syphilis in either of the parents' families.—*The Med. Press and Circ.*, Dec. 15, 1886.

White (W. R.) on a Case of Intestinal Obstruction in an Infant Caused by the Ingestion of Wool.—The patient was a girl twelve months old, still nursing, and getting besides breast milk a little bread and cracker. Ordinary symptoms of intestinal obstruction came on unrelieved by enemata administered by the mother.

Dr. White gave the child gr. ii. of calomel in sugar. The next morning there were four large painless stools containing, the mother said, two handfuls of pink, blue, and white wool that the child had picked from its blanket.—*Medical News*, Jan. 1, 1887.

Tannahill (T. F.) on Purple Suffusion of the Extremities Alternating with Attacks of Hæmatinuria.—M. N., aged five, female, has been subject to attacks of hæmatinuria for three years. The attacks occur after a chill, and are more frequent in cold weather. Between the attacks the arms and legs become, as the parents say, black and cold, pain is complained of, and apparently some loss of power in the legs and feet. These interim attacks are also associated with chill. The hands and feet, as far as the ankles, become of a deep purple tint, equally diffused and not disappearing on pressure. There are pain and tenderness in the parts affected. No sweating or swelling. The skin assumes a healthy appearance, and the pain subsides in less than thirty minutes. The urine looks normal, and is free from albumen. There is no real loss of power in the legs, but movement is restricted to avoid pain. The alternation of hæmatinuria with vaso-motor disturbance of the extremities in this case suggests a common origin of both.

Bearing in mind the reciprocity of skin and kidneys, a vaso-motor paralysis, similar to that observed in the extremities, may occur in the kidney, great congestion would ensue, and the coloring matter might escape. The short duration of the attack, in each affection, is reconcilable with temporary vaso-motor disturbance.—*Brit. Med. Jour.*, Dec. 18, 1886.

Wells (E. F.) on Pneumonic Fever in Pregnant Females.—It might be supposed that labor would very greatly increase the danger, but I feel assured that this is not the case, but rather the contrary. In quite a number of cases in which premature labor has occurred in the course of febrile diseases I have seen the temperature and pulse decline and the other symptoms ameliorated, even during the progress of labor, and this has also been the case in the few of my cases of pneumonic fever which were so complicated.—*Four. Am. Med. Ass'n*, Dec. 18, 1886.

Page (J. F.) on Parotiditis and Pregnancy.—Mrs. S., aged twenty-nine,

three months pregnant, was taken with parotiditis. On the third day the swelling abandoned the parotid glands, and miscarriage followed. She has had four previous pregnancies, of which the first, third, and fourth were normal. The second pregnancy miscarried, which was attributed to fright.—*Fourn. Am. Med. Ass'n*, Jan. 8, 1887.

Musket (P. E.) on Hydatid Cyst in the Scrotum.—The growth formed a tumor about the size of a large emu egg. Dr. Musket believes this to be the first recorded case of a scrotal cyst from this cause. He adds: As to unique situations for hydatid disease in my own experience, I have found, after death, in Douglas' pouch a cyst the size of an orange in a young girl who died of cardiac trouble. Had opportunity permitted an examination during life, it would doubtless have given rise to some difficulty in diagnosis. I have also been present at an autopsy where a cyst was met with in the pericardial sac. While house surgeon at the Sydney Hospital I saw a cyst, the size of a hen's egg, situated over the left deltoid muscle, which was taken to be an ordinary fatty tumor till it was exposed by the scalpel.—*N. Y. Med. Record*, Jan. 15, 1887.

Clibborn (J. B.) on Diphtheria of the Vagina without the Throat Being Affected.—Mrs. T—, the wife of a private in the Royal Marine Light Infantry, when attending her child, who was suffering from diphtheria, was scratched by him on the right wrist. Some days after (time uncertain), a few isolated, inflamed vesicles that were very painful appeared on the wrist, which implicated the glands at the bend of the elbow and axilla. There was no pyrexia, and the throat was not affected. The wrist soon healed under treatment, and the inflammation in the glands subsided, when a fresh crop of vesicles appeared around the nipples of both breasts; there was still no rise in temperature, and the patient complained of little inconvenience beyond weakness and general malaise. The latter crop of vesicles went away as rapidly as those on the wrist, but the patient complained of weakness, daily increasing, accompanied by anorexia, with insomnia; she also stated that there was a fetid discharge from the vagina. On making a vaginal examination the mucous membrane was found to be greatly inflamed, discharging pus and covered in parts with well-developed shreds of false

membrane. The constitutional symptoms now rapidly developed, asthenia increased, and the patient suffered at times from delirium and delusions, and had one well-marked epileptiform convulsion. The urine contained a small quantity of albumen. The highest temperature taken only indicated 90.4° , the throat at no time presenting an inflamed appearance. The inflammation in the vagina daily increased; large shreds of false membrane, almost forming complete casts of the vagina, were discharged; asthenia was great; the pulse, small and compressible; the pupils were frequently irregular, and responded feebly to light. About this period of the disease the patient (who was five months pregnant) was attacked with well-marked labor pains, occurring at regular intervals. As it was considered that, should a miscarriage take place, the disease would extend to the uterus, with a probably fatal issue, very large doses, of opium were given with a view of stopping the uterine contractions, which had the desired result after the patient had taken about five grains of this drug. Under treatment the discharge from the vagina became less and the development of false membrane decreased till about ten days after its first appearance, when it had entirely disappeared. Convalescence rapidly took place, and the patient, who was removed to the country, was subsequently delivered of a living child, with no bad results.

Treatment.—Carbolic acid combined with quinine was given internally every three hours (each dose containing one minim of carbolic acid, ten minims of glycerine, and one drachm of tincture of quinine, in an ounce of water), the urine being carefully watched during its administration. Iodoform was applied locally with vaseline (a drachm to the ounce). When the vagina became affected it was frequently washed out with a solution of permanganate of potash. Strips of lint soaked in iodoform and vaseline were introduced into the vagina and changed every few hours. Stimulants and strong liquid food were given in large quantities when the asthenia was great.

This is one of several cases I have treated with carbolic acid and quinine given internally in this disease; the results so far have been more satisfactory than any other treatment I have seen tried.—*Lond. Lancet*, Nov. 6, 1886.

Briggs (W.) on Diphtheritis of Urethra, Glans Penis, and Scrotum; Recovery.—About the first of the present month (December) I circumcised the six-year-old son of Mr. Z., for phimosis. The wound healed readily and kindly, and six days after the operation there was left only a small unhealed spot on the frenum. About this time the child took diphtheria and was attended by Dr. William Porter. On the 8th day after the operation, and two or three days after the outbreak of diphtheria, the child complained of pain in urination, but examination revealed no cause for the phenomenon. On the tenth day, the pain in micturition continuing, a further examination revealed the fact that the meatus was covered with a white membrane, which proved to be diphtheritic. This membrane rapidly extended until it covered the glans penis and reached the wound. Thence it passed down the inferior surface of the penis, and finally covered about one half of the anterior surface of the scrotum, where it was checked under applications of iodoform. The child made a good recovery and is now well.—*St. Louis Med. and Surg. Jour.*, Jan., 1887.

TOXICOLOGY.

Cameron (C. A.) on the Toxicity of Silicon Fluoride.¹—In 1882 a man employed in an artificial manure works died after a few hours' illness. An inquest was held upon his remains, at which the following facts were deposed to:—1st. That on the morning of the day upon which he died the deceased was in his usual health. 2d. That immediately after going into a small chamber termed the "den," in which was contained a quantity of freshly prepared superphosphate of lime, he became unwell and went to his home. 3d. That he complained of difficulty in breathing, and, after much suffering, died in the evening. 4th. That no poison was found in his viscera. The jury found a verdict to the effect that the deceased had died from inhaling "foul and poisonous gases."

On the 26th of October, 1883, a young man employed in this manure factory, died after a few hours' illness. In this case, too, there was an inquest, and the verdict of

the jury was that "John Murphy died from inhaling foul gases."

John Murphy entered the factory for the first time on the morning of the day upon which he died. He was employed in "mixing manure." At 9 o'clock he came home to breakfast. His sister remarked that he had a muffler round his mouth, from which it may be inferred that he had been protecting his lungs from some irritant gas, vapor, or dust. He returned to the factory at 10 o'clock, but an hour later came home, and said that he was "smothering," and lay down on his bed. Soon after he "threw up froth and other matters," his sister said, and he cried out constantly for air. A neighbor who saw him at half-past 1 o'clock testified that his nose, cheeks, hands, and feet were purple; his head, but not his body, was cold; he was "gasping for air," breathed with difficulty, and insisted on having the back of his neck and chest uncovered. At half-past 7 o'clock p.m. the police removed him to Dr. Steeven's Hospital, where he expired a few minutes after his admission, remaining conscious up to his death. He informed Dr. Myles, resident surgeon, that he had been drinking very hard, but not during the previous week. He said that he had been working in a chemical manure factory, and that he was "choking." His breathing was very hurried and he spoke with difficulty.

The viscera were submitted to me for examination. No poison was detected in the stomach, liver, or kidneys. The lungs were somewhat œdematous, and in several parts presented the appearance to which Niemeyer has applied the term of "permanent inspiratory vesicular ectasia." The pulmonic veins were greatly congested, and the pulmonic capillaries distended. The blood was very dark, and the bronchi were plugged with frothy mucus. The right cavities of the heart were distended with clotted blood, whilst the left cavities were nearly empty. There was hemorrhagic infiltration of the cardiac muscles; heart otherwise healthy. The liver was congested, a portion of it presenting the "nutmeg" appearance sometimes met with in the case of intemperate persons. With the exception of some slight adhesions between the costal and visceral pleuræ, and some other evidence of former pulmonary disease of no serious character, the "nutmeg" liver was the only abnormality revealed by

¹ For therapeutic employment of hydrofluoric acid see *MEDICAL ANALECTIC*, 1886, pp. 4 and 394; for the fluorids of ammonia and iron *ibid.*, p. 260.

the examination. The symptoms in this case and the condition of the lungs and heart shown by the post-mortem examination indicated death by asphyxia.

On thinking over the case, I came to the conclusion that he had been killed by inhaling fluoride of silicon gas, and I immediately proceeded to put my theory to such proofs as the case admitted of.

When fluoride of silicon comes in contact with moisture, silicic and fluosilicic acids are formed. If the deceased had inspired silicon fluoride, silicon should be present in his respiratory organs, and fluorine might also be found therein. An analysis of a portion of the lungs showed that the whole organ contained at least 0.75 gramme of silica (Si O_2). Minute quantities of silica have been found in the bones, and perhaps in other parts of man, but the quantity present in the lungs of John Murphy was so very large as to preclude the possibility of its being a normal constituent of the organ. As no dust was noted in the trachea of the deceased, the silicon and fluorine could not have been inhaled in the form of powdered coprolite or other phosphate.

I procured a specimen of the phosphatic material used in the factory at the time of Murphy's death. It was of the kind termed "Charleston Phosphate," and its composition was as follows :

100 parts contained—		
Water and organic matter	.	8.00
Calcium phosphate	.	57.25
Calcium carbonate	.	14.45
Calcium fluoride	.	6.36
Alumina and ferric oxide	.	6.44
Silica and insoluble silicates	.	7.50
		100.00

The amount of fluoride of calcium in this phosphate was unusually large. On treatment with acid it would evolve very large amounts of carbon dioxide, and fluorine compounds.

That John Murphy died from asphyxia, caused by inhaling deleterious gases or vapors, is beyond doubt; and it seems to me equally certain that these gases were oxides of nitrogen, carbon dioxide, and silicon fluoride. To what extent the two former contributed to the fatal result I know not, but I have little doubt that the silicon fluoride was the principal, if not the sole, cause.

Action of Silicon Fluoride on the Respiratory Organs.—When silicon fluoride comes in contact with the moist surface of the

respiratory passages, it deposits thereon gelatinous silica and fluosilicic acid. The silica being in the colloidal state, opposes great resistance to the passage of gases, and it forms a glaze, or varnish, on the walls of the bronchi and their ramifications. As it is not absorbable into the circulation, it can only be got rid of by expectoration. It probably acts as an irritant to the nerves of the smaller bronchi, causing their muscles to contract spasmodically, thereby diminishing the area of the passages between the trachea and the air vesicles. The plugging of the smaller bronchi with the colloid silica undoubtedly impedes to a large extent the access of air to the lungs. The fluosilicic acid, no doubt, contributes to the toxic effect produced by inspiring silicon fluoride. Being readily soluble, it is highly probable that it passes into the circulation and acts as a nerve poison. It may act directly upon the filaments of the pneumogastric nerve, which come in contact with it, and paralyze their action.

Effects of Silicon Fluoride on Animals.—

Into a glass vessel of 47 litres' capacity 0.47 litre of silicon fluoride was introduced, and when it was concluded that the atmospheric air of fluoride of silicon were equally mixed, a rat was introduced into the vessel, which was immediately closed. Owing to the air in the vessel being imperfectly dried, much of the silicon fluoride was at once decomposed, and it is probable that the air inspired by the rat did not contain quite a half per cent. of the fluoride. The animal sat up, rubbed its nose with its forefeet, and made attempts to escape. Its breathing was very rapid. The deposit of silica upon the interior surface of the vessel soon obscured the animal's movements. After twenty minutes' exposure to the atmosphere of the vessel the animal was removed. It was then quite passive; but its heart beat rapidly, though feebly, and its respiration was hurried, and occasionally there were spasms of the muscles of the limbs, especially of the flexors. It survived four hours.

The glass vessel having been filled with perfectly desiccated air, the latter was mixed with 0.5 per cent. of its volume of silicon fluoride, and a healthy guinea-pig, weighing 1 lb. 1 oz., was introduced into the gaseous mixture. It immediately exhibited signs of irritation, scratching its nose and shaking its head. The film of

silica which formed upon the moist surface of the eyes caused the animal to close them, but it occasionally opened them to examine its surroundings. After five minutes it made a few feeble attempts to scale the side of the vessel; it staggered about, and could not maintain itself straight upon its legs. After ten minutes it lay upon its abdomen. At the expiration of fifteen minutes the animal was taken out of the vessel. Its respirations were shallow, and its heart fluttered rather than beat. Loud murmurs were heard in that organ, and the bronchial râles indicated the presence of much mucus in the bronchi. On being turned upon its back it regained its former position—lying upon its abdomen. Twelve minutes after removal from the vessel it lay in any position in which it was placed, and three minutes later it expired.

A strong guinea-pig, weighing 2 lb. 1 oz., was placed in a mixture of 98 parts of air and 2 parts of silicon fluoride. The animal instantly exhibited signs of irritation, and struggled to escape from the vessel; but its efforts soon became feeble, and ceased completely within four minutes. One minute later the animal appeared to be dead; and upon removing it from the vessel, no cardiac movements could be detected.

An examination of the respiratory organs of the animals that had been killed by the silicon fluoride showed that the respiratory passages down to and including some of the air vesicles in the lungs were coated and some of them plugged with colloid silica. The lungs were dark in color and highly congested, and there were blood-clots in the right cavities of the heart.

The foregoing experiments prove that fluoride of silicon is a more powerful poison than carbonic acid, or even carbon monoxide. They do not, however, show precisely the action of the poison. It undoubtedly causes (like carbonic acid) imperfect arterialization of the blood, and distension of the right side of the heart. It does not, however, when inspired in fatal doses, appear always to produce insensibility, as carbonic acid does. It is probable that its action is more complex than that of carbonic acid. The silicious glaze and plugs already referred to induce a certain amount of asphyxia by narrowing the respiratory passages, and the fluosilicic acid may act as a poison to the nerve centres which control respiration.—*Dublin Jour. of Med. Sci.*, Jan., 1887.

Mackenzie (C.) on Mercury-Poisoning in an Infant; Appearance of the Unchanged Metal in the Stools.

—A child with pertussis broke a thermometer, and succeeded in swallowing about two drachms of the quicksilver. No bad symptoms were observed for a week, when the patient was attacked with a severe diarrhœa, accompanied by tympanites. Dr. Mackenzie saw the child two weeks after the accident, and from the location of the pain, the tympanites, etc., he was led to make a diagnosis of perityphlitis. Three days later about a teaspoonful of pure mercury was found on the diaper. Other evacuations of the metal occurred, and the child recovered. There appeared to have been no oxidation* of the mercury.—*Am. Jour. Obstet.*, Dec., 1886.

Armstrong (S. T.) on Recovery from an Overdose of Mercuric Chloride.—A male, aged thirty-five years, poured out, he judged, a quantity of corrosive sublimate solution that contained six grammes (ninety grains) of mercuric chloride—and drank it at a gulp. As soon as it passed his throat, he knew from the burning sensation, that he had taken something wrong.

Almost instantly violent cramping and vomiting occurred, soon augmented by free purging and micturition. The hospital steward returning within an hour after the poison was swallowed, found the man coiled up on the grass, and learning from him that he had taken something from the medicine case, gave him, on general principles, a dose of sweet-oil. I saw the man shortly afterward. His face was pale, eyes sunken, expression anxious, voice stridulous—he spoke with difficulty; heart's action feeble and rapid, skin cold. Insatiable thirst, and continued vomiting of the few drops of water he momentarily swallowed. Tormina and tenesmus, with occasional evacuations of a small quantity of intestinal mucus. Copious micturition.

To counteract the collapse a hypodermatic injection of atropia sulphate 0.002 gramme was given, and the patient put to bed.

An inspection of the pharmacy was made, and a graduate found containing a white deposit on its side; an examination soon showed this to be mercuric chloride, and a glance at the medicine shelf explained the source of his potations. In consideration of the potency of the poison, and the con-

dition of the patient, the case was prejudged hopeless. Reaction, however, followed the hypodermatic, he became stronger during the night, and though very weak the next morning, gave promise of recovery. The subsequent history of the case is unimportant; intense salivation occurred, which was treated as usual, and the case discharged, recovered, on November 11th.

It is considered that the alcohol (60 c. c.) first drank had dehydrated the mucous membrane of the œsophagus and stomach, rendering absorption slow, and the excessive dose of the bichloride proved so irritating that he vomited most of it.—*Medical News*.

North (Jno.) on Canned Foods as a Cause of Acute Poisoning.—The following symptoms have been recorded as occurring in acute poisoning from canned foods:

Brain—Headache, throbbing of temples, vertigo, delirium, stupor, coma.

Face—Livid.

Eyes—Red, suffused, lids swollen, pupils dilated.

Tongue—Fiery red, heavily coated.

Throat—Dry, burning sensation, extreme thirst.

Stomach—Want of appetite, repeated eructations, nausea, retching, violent vomiting, both bilious and alimentary.

Bowels—Tender, painful, griping, diarrhoea, violent colic, gastro-enteritis, very offensive stools, bloody stools, dark tawny liquid from bowels, stricture of rectum and colon, tenesmus, prolapse of rectum.

Respiration—Alternate strangulation and paralysis of lungs.

Temperature—Normal, 101° to 105° F.

Pulse—Weak and slow, thin, thready, 100 to 150.

Integument—No heat of skin, skin hot and dry, profuse sweating, fiery red eruption all over body, intolerable itching, rough skin, greenish or yellowish patches.

Kidneys—Urine scanty, loaded with urates, no sugar nor albumen.

Muscles—Convulsive tremors, all movements painful, cramps of thighs and legs, epileptiform convulsions, partial paralysis of extremities.

General Symptoms—Cross, irritable, great languor, extreme weakness, typhoid condition, cold extremities, etc.

When a number of persons are taken sick after eating foods that have not been

canned, the food is analyzed for the purpose of ascertaining what poison has been introduced into the food by some malicious person. Failing to find metals or natural alkaloids, the case is reported as one of mysterious poisoning. Cases of this class are reported nearly every day by the public press. Poisoning of wedding and other parties from eating ice-cream, made in old freezers with portions of putrid milk adhering to the creases and corners of said freezers, are known to all of us. Many seem to be under the impression that the toxic symptoms must necessarily be caused by a metal or microbe. Now, heating to the boiling point (212° F.) will destroy all organic germs, but not all the alkaloids.

In conclusion, if care is used in canning foods, and they are not allowed to decompose before or after canning, they will not give rise to acute poisoning—*Four. Am. Med. Ass'n*, Jan. 8, 1887.

Foulerton (A. G. R.) on Poisoning by Benzoline Vapor.—W. S.—, aged twenty-five, a well-made and healthy-looking German, entered a zinc tank used for the storage of benzoline, and then all but empty, at 9 A.M., and at 11 A.M. was found lying insensible at the bottom of it. The tank was some 5 ft. 6 in. high, with a small man-hole at the top, and exposed to the direct heat of a powerful sun, a thermometer inside registering 105° F. Shortly afterwards, when the man was brought to the infirmary, I found him in the following condition: Smelling strongly of benzoline; unable to stand, but capable of answering simple questions in an indistinct sort of way; moaning occasionally, and from time to time bursting into an hysterical laugh; face flushed; surface of body and limbs cold and clammy; muscular tremors and twitchings in the legs and arms; pupils widely dilated, reacting to a strong light stimulus; pulse 88, full and soft; respiration from 8 to 9 in the minute, deep, and stertorous, irregular in rhythm, as much as fifteen seconds intervening between the separate inspirations; heart's action feeble; temperature in axilla 98.8°. Shortly after admission he vomited freely, the ejected matters being bile-colored and smelling of benzoline.

The man was given at once twenty-five minims of solution of ammonia with half a drachm of ether and put to bed, wrapped up in blankets, and hot-water bottles used. He then had half a drachm more of ether

with some brandy, and was given frequent half-drachm doses of aromatic spirit of ammonia. For about two hours the patient remained in much the same condition, becoming at times absolutely unconscious, his breathing also getting worse at intervals. At the end of that time he began to improve rapidly, and was soon afterwards able to give a rational account of himself, but could not say how long he had been in the tank before he lost consciousness. His pupils were still dilated, and he complained of bad headache. He then had an attack of profuse sweating, and by the evening had completely recovered, no trace of his misadventure remaining beyond some slight headache. The temperature and respiration were normal, and the pulse 76. The urine passed presented nothing extraordinary, and a motion following the administration of half an ounce of castor-oil was of a dark-green color.

Looking back on the case, I cannot help thinking that the man might have been further benefited by a little blood-letting, for I regard the main symptoms as pointing to failure of the heart's action, diminished capillary tension, and consequent stagnation in the venous system, with over-distension of the right side of the heart. Were a similar case to occur to me again, I should be content, I think, with the application of external warmth and moderate bleeding and the free use of ammonia.—*Lancet*, Nov. 6, 1886.

MISCELLANEOUS.

The Treatment of Persistent Priapism.—Two cases of persistent priapism have been recently reported, the results of treatment in which were more than usually successful. Dr. T. H. Burchard, of New York, reports a case of an intermittent nature of three years' duration,¹ in an Englishman of fifty-three. The condition in this case seemed to follow financial losses and grief. The trouble seemed to commence with erotic dreams and frequent nocturnal emissions. Erections next came on frequently during the day, lasting from one to three hours, without emission. He got some relief by foot and horse-back riding in Switzerland. Under the advice of various English and continental physicians he was treated by enormous doses of bro-

nides, by camphor, opium, cannabis, ergot, chloral, arsenic, galvanism, hot and cold spinal douches, without any appreciable effect. Dr. Burchard recommended the following empirical but rational treatment:

1. To preserve his vitality in the best condition possible, and to husband his strength, he was put to bed. For the relief of his dyspepsia he was put upon a diet of peptonized milk.

2. Believing that there must be impaired circulation through the cord, spinal spongings of very hot and very cold water, applied alternately down the spine for a period of ten minutes, were employed three times a day. This sponging was used in preference to galvanization, because he had repeatedly received galvanic treatment at the hands of experts abroad without benefit.

3. To relieve any possible congestion that might be existing, applications of the actual cautery were made down the dorsal and lumbar spine on three occasions. The most marked improvement followed these applications.

4. In order to control the circulation of the cord, the fluid extract of ergot was administered in drachm doses, at first three times a day, this being increased later on to a drachm each three hours. Hypodermics of the hydrochloride of strychnine, commencing at one sixtieth of a grain and increasing to one twentieth of a grain, were given each day.

5. To abort the paroxysm, a spinal ice-bag was applied to the spine at the commencement of the paroxysm, and a full dose of morphine with atropine was administered hypodermically. Upon two occasions, when the paroxysm did not yield to the morphine within twenty minutes, chloroform was given by inhalation.

At the expiration of the second week of the foregoing treatment the general condition of the patient had so far improved that, in addition to milk, he was taking a full farinaceous diet, with boiled fish and the white meat of chicken. His erections were now occurring not more than once or twice in twenty-four hours and were far less severe.

During the third week of treatment, on two different occasions he passed the twenty-four hours without an erection, and at no time did he have more than one paroxysm a day, lasting about fifteen minutes. During the same week the hot and

¹ *N. Y. Med. Jour.*, Jan. 15, 1887.

cold douches were discontinued, and a mild descending current was applied to the spine for ten minutes each day.

The progress of the case from this time on was one of rapid improvement. I saw the patient on the second of the present month, and found that during the three months and a half since the commencement of treatment he had gained thirty-five pounds in weight, and had had no erection further than any normal man might experience for a period of over two months.

Another case¹ was observed by Dr. J. L. Dawson Jr., of Charleston S. C., and occurred in a negro man of thirty-five after considerable fatigue and exposure. The patient had tried nature's remedy and crushed ice without avail. Dr. Dawson tried in the order named the following remedies: hot fomentations, ice-bag, bromide of potassium alone and with chloral hydrate, urethral injections of cocaine solution, faradism, brisk cathartics, suppositories of belladonna and opium, sulphate of morphia, and, finally, incision into corpora cavernosa (under chloroform). The author then says: Having failed in every expedient, we determined to continue the bromides and watch the case. During the priapism there is no difficulty in the passage of the urine, the patient emptying his bladder easily. The erection continued for ten days, and nothing further was done beyond the application of tobacco poultices and the administration of stimulating enemata, which seemed to have little effect. The turgescence began to subside on the tenth day, and in four or five days the penis had gradually returned to its normal flaccidity.

Nearly two months have elapsed; the patient enjoys his usual degree of health, and has returned to his work, but he is unable to have an erection. He has attempted the act of copulation several times, but the penis remains flaccid, although he asserts that he has an orgasm with ejaculation.

Waitzfelder (E.) on a Case of Bitemporal Hemianopsia.—A lad, whose general history was negative until five months ago, then noticed a "blur" over the right eye. He then consulted Dr. P. A. Gallan, at the New York Eye and Ear Dispensary, who diagnosticated right temporal hemianopsia. The condition grew

worse, the left optic nerve became involved, and left temporal hemianopsia developed. The nasal fields of both eyes were unaffected. Two months ago the patient had choked disk in the right eye. His condition November 1st was as follows: No other basal nerve affected; he has complete bitemporal hemianopsia, the whole of fixation point being included in the seeing field. Theoretically, the fixation should be dissected, but practically, it never is; there is atrophy of both optic nerves, most marked in the right. Vision, R. E. $\frac{8}{cc}$; L. E. $\frac{20}{xx}$. Diagnosis: tumor of the chiasm in the anterior portion; pressure upon the fascicula cruciata of both optic nerves, the fasciculi laterali being as yet unaffected. There is no tubercular or syphilitic history. The rapid growth of the lesion points strongly in the direction of sarcoma.—*Medical News*, Nov. 20, 1886.

Lang (W. S.) To Ascertain whether Gangrene is Likely to Follow Severe Injury of a Limb.—Gently raise the limb, and keep it raised for two or three minutes, in order to empty it to some extent of blood, then apply a tourniquet, or piece of elastic webbing, on the proximal side of the injury, and keep it applied for about a minute—lower the limb, remove the tourniquet, and if sufficient circulation remains, the part beyond the seat of injury will blush rosy red, and will show in an unmistakable manner the condition of the blood-vessels.

This procedure was adopted by the writer in a case of severe compound comminuted fracture of both bones of the leg. The limb was almost "dangling" and apparently hopeless, but after having adopted the process above described, it was observed that the dorsum of the foot blushed after the elastic webbing had been relaxed.

The boy made an excellent recovery with a useful limb.—*Edin. Med. Jour.*, Jan., 1887.

PUBLISHERS' NOTES.

Horsford's Acid Phosphate.—Dr. W. W. Gardner, Springfield, Mass., says: "It seems almost tautological to recommend Horsford's Acid Phosphate as a valuable local and stomach tonic. I have made use of it in my family and in practice for years. I will however repeat what my practice confirms, that I value it, when taken according to directions, as an ex-

¹ *Medical News*, Jan. 15, 1887.

cellent preventive of indigestion, and a pleasant acidulated drink when properly diluted with water and sweetened."

Cod-Liver Oil.—Scott & Bowne, manufacturing chemists of New York, make a specialty of producing an emulsion of cod-liver oil with hypophosphites. Their great care in selecting the oil and in making the combination is amply proven by the high therapeutical value set upon the emulsion by the profession. It is no new remedy, but has been steadily growing in demand for a number of years. It is certainly very useful in restoring wasting tissue, and in cases of scrofulous children it acts almost as a specific. They also offer a Buckthorn Cordial which is highly useful in the treatment of constipation.—*Massachusetts Eclectic Medical Journal*.

Colden's Liquid Beef Tonic.—I cheerfully state that I have tested the virtues and efficiency of "Colden's Liquid Beef Tonic" in my private practice, in cases of general debility, weakness, depression, dyspepsia, loss of appetite, and nervous afflictions, when medicine had proved more than useless. I have found it the best remedy I ever used in chronic alcoholism, when the stomach is always irritable, and food required to nourish and invigorate the drooping strength and nervous depression; also appeasing the thirst for more alcohol.

Dr. WM. ALEX. GREENE, Macon, Ga.

Crystalline Phosphate.—Provident Chemical Works.

Gentlemen:—The Crystalline Phosphate is an excellent preparation; I have had great satisfaction from its use and can highly commend it. Very truly,

J. P. GEPPERT, M.D.

Cincinnati, Ohio.

Peacock's Bromides.—I have had occasion to use Peacock's Bromides and found it valuable—the best preparation to meet cases demanding bromides I have ever used.

A. W. BURNSIDE, M.D.

811 Washington Boulevard, Chicago, Ill.

Lactated Food.—

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April 15, 1896.

Wells & Richardson Co.

Gentlemen:—I have been prescribing your Lactated Food considerably for some

time past and I pronounce it a truly valuable remedy, as it has universally produced satisfactory effects in every instance where it has been administered. Therefore I shall still continue to prescribe its use.

Respectfully, W. H. MAY, M.D.

Murdock's Liquid Food.—Extract from Dr. G. B. Peck's (of Providence) Essay before the Thirty-third Congress of the American Institute of Homœopathy, at Milwaukee, Wisconsin; subject: "Placenta Prævia: a Study concerning the Use of Medicaments for Hemorrhage Prior to Inception of Labor":—

"Symptoms resulting from the loss of blood should, of course, be treated by their similia; so generous a diet will be given as the condition of the patient will permit. Above all things else stands 'Murdock's Liquid Food.'"

Iron-Alum Mass.—I have prescribed the "Seven Springs Iron-Alum Mass" in many cases of scrofulous diathesis, and expect to prescribe it in many more, for I do not know of any remedy that would give better satisfaction.

WM. WHITE, M.D.

Abingdon, Va.

Women's Medical College.—Send to Dean of the College for catalogue, mentioning the ANALECTIC.

Viburnum Compound.—This excellent preparation has been used successfully by over one thousand physicians. Send for circular and samples.

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THE MEDICAL ANALECTIC

A
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R. W. AMIDON, M.D.

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LEADING ARTICLES.

Actinomycosis Hominis.—Dr. E. M. Skerritt, in the *American Journal of Medical Sciences* for January, 1887, says that this disease is defined by Ziegler to be a progressive inflammatory affection, set up by a certain fungus—the actinomyces—resulting in the formation of granulations and fibrous tissue and in suppuration; attacking human beings, cattle, and swine, and communicable to cattle by inoculation. In the Western United States, this disease, when occurring in cattle, is known as “swell-head,” and usually affects the lower jaw; the upper jaw, the tongue, and soft parts about the mouth being more rarely affected.¹

Bollinger first described the disease as occurring in cattle (1877). Israël, in 1877, described this same organism as occurring in man. Ponfick, in 1879, recognized the true nature of the disease, and showed its identity with that described by Bollinger.

The fungus occurs as small globular masses, commonly about the size of a millet-seed, usually of a pale-yellow color, but at times white, brown, green, or speckled, with a surface closely covered with palisade-like rows of clubbed bodies, which give it a mulberry-like appearance. Each mass consists of a central core of closely-woven threads, from which radiate a multitude of filaments, which swell out at their ends into the club-shaped bodies before mentioned; these form the outer part of the mass, and cause its peculiar appearance. In man the clubbed bodies are commonly absent, and the growth consists of the radiating filaments alone. The etiology of the disease is unknown and the fungus has not been recognized outside the body.

It may first appear as a growth upon the

lower jaw, or a tremor in the neighboring soft parts, or, more rarely, in the upper jaw, where its growth is slow. It may first invade the respiratory tract, affecting the bronchial mucous membrane or the pulmonary parenchyma, where it sets up a peribronchitis or pneumonia. Finally, the invasion may be through the intestinal tract.

When the lung is first attacked and a peribronchitis or pneumonia results, the cells in the alveoli undergo fatty degeneration, and are replaced by tubercle-like masses.

They often soften and suppurate, and cavities are then formed, about which a connective-tissue growth occurs. As this growth increases the alveoli are compressed, and the affected portion of the lung is changed into a dense mass of connective tissue, containing cavities lined with granulation tissue, in which the growth is embedded. With this change there is a contraction of the lung, which may be marked, and causing a falling in of the chest-wall. The sputa may be muco-purulent, or slight hæmoptysis may occur, and the microscope will usually reveal the presence of the fungus.

In some cases the disease extends from the lungs to the tissues about the vertebræ, or down behind the diaphragm into the retro-peritoneal tissues, or involves the liver, spleen, or pericardium, or invades the peritoneal cavity through the diaphragm.

Finally, the skin may become involved, give way, and allow the escape of fluid containing the fungus.

When the intestines are first involved, the actinomycotic tumors form in the mucous or submucous tissues.

These in some instances soften, and their contents disappear with the fæces, and the ulcers left heal.

Usually, however, the abdominal viscera are secondarily involved.

¹ Dr. Geo. H. Rohé: *New England Medical Monthly*, Sept. 15, 1886.

Dr. Rohé states in his article that in 1885 Israël collected thirty-eight cases, occurring in various parts of the body, with sixteen recoveries and twenty-one deaths, and one unimproved. In these thirty-eight cases, the points of localization in sixteen were as follows : one in the lower maxillary bone, eight near it in the submaxillary and submental regions, two in the neck, one in periosteum of superior maxillary bone, and four in the buccal region. He does not state whether these were the cases that recovered. As the treatment is primarily local—removal of the growth as completely as possible, with scraping of the tissues about it, and the use of germicide solutions—the prognosis is good in cases that admit of operative treatment, while in other cases it is almost hopeless.

Dr. Skerritt reports the case of a man, aged twenty-eight, a house decorator whose father and one brother died of phthisis.

For three months before admission to the hospital, had not been in usual health. For five, loss of appetite and apathy. For three weeks sharp pain in right chest, marked loss of flesh and for two weeks night sweats. When admitted heart and lungs normal except weak breathing over right chest, posteriorly. Abdomen distended. Pain over liver, which was slightly enlarged. Three weeks later dulness noted with weakened voice and breathing over right chest anteriorly. Night sweats, cough, muco-purulent sputæ. Temperature from 98°–103°. No vigor. For next two weeks symptoms persisted, after which marked improvement in the right side of the thorax took place, and cough became less troublesome. A week later rigors followed and the sweats were more marked, no vomiting, diarrhoea, or jaundice. Microscopic examination of sputa negative. Patient died sixteen weeks after admission. The lower lobe of right lung was adherent to chest wall and diaphragm and the latter to the liver ; this part of the lung was changed to dense fibrous tissue with no visible lung structure left. In the liver a tumor of peculiar structure and about the size of a large orange was found. In this tumor was a small amount of pus and spherical bodies characteristic of actinomycosis. The case affords an illustration of the migration of an actinomycotic tumor, its having first appeared in the lung, passing thence through the diaphragm to the liver, leaving a dense cicatricial tissue to mark its course. The

diagnosis was not made during life, though the disease was suspected and the fungus sought for in the sputa. Dr. Skerritt's article contains six cuts illustrating the structure of the growth, which is fully described.

In the London *Medical Record* for Feb. 15, 1886, is the translation of an interesting article on primary broncho-pulmonary actinomycosis in man, dealing particularly with its diagnosis, which he says can always be made by examination of the pathological products eliminated.

It should be suspected in every case of bronchial catarrh in which the sputa are scanty, emit a disagreeable odor, and are gelatinous in appearance (like red-currant jelly) ; in bronchial catarrh simulating pulmonary tuberculosis, yet running an apyretic course ; in all cases of alteration of the shape of the thorax coming on slowly ; above all in cases of chronic broncho-pulmonary symptoms in which very painful phenomena arise, and in all tumefactions of the chest wall wherever situated. In these cases the sputa should be carefully examined for the fungus.

Dr. A. Shirmer,¹ in October, 1886, reported the following case, the patient then living: Male, twenty-five years of age, worker in a lumber-yard. When eighteen years of age (at that time a farm laborer), while chopping wood received a slight incised wound of chin ; shortly afterwards noticed swellings on both sides of lower jaw, and the one on the right remained. Some four months later this opened and discharged a small amount of pus and a fistula was left. Since then has not been able to fully open his mouth. Three years ago, on account of severe cold, unable to work for a week. Otherwise in good health. In July, 1886, patient complained of pain in left side and stiffness of neck. The fistula was dissected out and pieces of necrosed bone removed. Two abscesses in the neck were opened at intervals of ten days, discharging a small amount of pus, containing granules which proved to be actinomycetes. The fungus was found in the sputa, which was rather profuse, the patient having a severe cough, which symptom, with that of fever, was becoming more marked when the case was reported.

Dr. A. J. Ochsner² also reported a case of actinomycosis at the November meeting of

¹ *Chicago Med. Jour. and Ex.*, Oct., 1886.

² *The Medical Age*, Dec. 10, 1886.

the Chicago Medical Society, where the patient was shown. He was a stock-raiser, aged fifty-six, and entered the hospital October, 1886. In autumn of 1877, after exposure to a draft, had severe neuralgic pain in left antrum of Highmore, which remained during the daytime until about six months later a spontaneous opening into the pharynx took place, evacuating considerable pus and giving patient much relief. The cavity was then opened above the first molar tooth, and curetted and irrigated three times daily for two years.

In July, 1885, began to cough and expectorate, which he continues to do. In October, 1886, began to expectorate mucus and pus streaked with blood. Has lost thirty-seven pounds in weight. On left side of the chest is decrease of motion, dulness, roughened respiratory sounds, and numerous mucous râles. Right side normal. Microscopic examination of the sputum revealed the characteristic fungus. The patient had treated many cattle affected with "lumpy jaw" by opening the abscess, extirpating the lump, and introducing powdered arsenic into the cavity.

In the *Medical Record* of January 15, 1887, is an account of a case of actinomycosis then under observation in Professor Albert's clinic in Vienna. The patient was struck on the abdomen by a heavy hammer and confined to bed about two weeks. Nine months later a swelling began to develop in the inferior abdominal region, and three days before admission a spontaneous opening took place. From this opening pus escaped, in which the characteristic fungus was found. None were found in the sputa. The man's general health was good and an operation would be performed.

Since cases of this rare affection have been reported and discussed in journals and before societies, and the attention of the profession thus directed to the importance of making microscopical examinations of the discharges from abscess, the causation of which is not clear, and in doubtful cases of lung disease, a larger number of cases will probably soon be recorded and the etiology of the disease made more clear. G. B. PHELPS, M.D.

Urethan.—In previous notes¹ the chemical and physical characteristics and some of the physiological and therapeutic effects of this drug have been set forth.

It seems to be one of the few therapeutic novelties which is not entirely disappointing.

According to Dr. J. Leech, it is sometimes met with having a disagreeable mousey odor, like that of acetamide, and forms, when dissolved in water, a nauseous solution. When properly made, it ought not to have any unpleasant smell or taste.

Dr. von Jaksch (*Wiener med. Blätter*, Nos. 33 and 34, 1885) has employed it 110 times in 20 cases of very different characters. The dose was usually 4 to 15 grns. It is well borne by the patients, and produces no unpleasant effects. The sleep lasts, as a rule, some hours. In the *Practitioner*, Feb., 1886, Dr. Saundby, of Birmingham, states that he has found it a very efficient hypnotic, in 2-grn. doses, in cases where paraldehyde had failed.

Anrep (*Pharmac. Post*, Oct. 23, 1886) has experimentally proven that urethan possesses properties antagonistic to convulsion-producing agents, such as strychnine, resorcin, and picrotoxine, and consequently claims that urethan could be utilized in intoxications caused by the named drugs. The efficacy of urethan rivals in this respect that of hydrate of chloral, but is far less dangerous, as it can, even in large doses, be given with perfect safety. Anrep concludes that in man 2 to 3 drachms of urethan would be required in order to counteract the intoxications with any of the foregoing drugs.

Kräpelin (*Neurologisches Centralblatt*, March 1st.) has given the drug in about 200 instances. Most of his cases were cases of insanity; but thirty-four instances of various other diseases were included. The dose ranged, as a rule, from 15 to 45 grains; occasionally a dose of 60 grains was given. No unpleasant effect on the heart or nervous system, either during the action of the drug or afterwards, was ever noticed. In one case of alcoholic gastric catarrh, vomiting was produced by the larger dose. The appetite, however, was never in the smallest degree impaired, even by the continuous use of the drug for several weeks. Urethan acts as a genuine hypnotic. Ten or fifteen minutes after taking it, a quiet sleep comes on, which lasts for several hours, and from which the patient wakes up without any unpleasant feeling about the head. Should the sleep be interrupted by any external cause, the patient generally falls off to sleep again as soon as the disturbance is removed. The

¹ MEDICAL ANALECTIC, 1886, pp. 158, 261, 271.

certainty of the drug's action depends upon the cause of the sleeplessness and on the dose. It is not an hypnotic of great energy, and, in cases of great excitement, it is of little value. In such cases it is far inferior to paraldehyde. In delirium tremens especially it failed. Perhaps, however, if higher doses were given in these cases the result might have been more satisfactory. For the relief of pain, the author does not consider it of any use whatever. In cases of phthisis, the combination of a small quantity of morphine was found useful. When given in doses of 15 grains it acted sufficiently in 54 per cent. When the dose was 45 grains, the result was favorable in 70 per cent. The form of mental ailment in most cases was general paralysis or melancholia. In the excited stages of general paralysis, small doses were frequently altogether without effect. The larger doses, in such cases, gave a satisfactory result in 60 per cent. of the cases. In the higher degrees of excitement—in mania, for example, as well as in delirium tremens—the author found himself obliged to have recourse to paraldehyde. In melancholia, the drug gave better results: it secured quiet sleep in 77 per cent. The patients were all women, and many of them were very anæmic. Amongst the most favorable indications for urethan, the author places exhausting diseases, feverishness, and lowered nutrition.

Drs. Otto and König have published their results in the *Centralb. für Nervenheilkunde*.¹ It was used in various cases of excitement, all of which are said to have been of a violent nature, epileptics and hysterical patients, and in the stages of excitement which so frequently occur in idiotic children. In twenty-three cases two hundred and fifty doses of this drug were given in watery solution; as much as from thirty to sixty grains or even one hundred and twenty being given without producing disagreeable results. In ten cases of epilepsy, with depression and anxiety, its action was favorable. The authors' most favorable results were, however, obtained in the case of idiotic children, where twenty to forty grains produced a very satisfactory result, without any disagreeable after-effects. In some of the cases, after the administration of

the large doses, nausea was complained of; vomiting occasionally occurring, the patients objected to continuing the treatment with this drug, although the taste itself was not disagreeable to them.

In cases of violent excitement, urethan, even in doses of one hundred and twenty grains, produced no appreciable relief, and the authors think that its employment is best suited to cases of slight depression and anxiety, as seen in their epileptic cases.

The cases in which Dr. Myrtle prescribed it (*The British Medical Journal*, 20th February, 1886) were of the usual run of every-day practice, where a sedative and hypnotic was required: general restlessness, sleeplessness, neuralgia, catarrh, certain forms of skin affections with great irritation, also rheumatism and gout. One gentleman who had suffered from insomnia for weeks, and cannot tolerate opium or chloral, took fifteen grains at bedtime with the most perfect result. He said: "The sleep caused was most pleasant and refreshing. I awoke without a headache, with appetite for breakfast, and, what was equally agreeable, there was no interruption to any of my functions." In smaller doses its action is less marked, still it is decidedly calmative and agreeable, causing no unpleasant effect, such as nausea, flatulence, constipation, or headache. It does not affect the nerve centres of circulation or respiration, but spends itself on the cerebrum. It possesses, therefore, great advantage over the older and valuable sedatives, which have certain evil influences, especially in exceptional cases. Given in gout and rheumatism in full doses, alone or in combination, it has the great advantage over morphia of not interfering with the action of the bowels or kidneys.

Dr. Dickson (*Deutsche med. Zeitung*, January 25, 1886) concludes that urethan appears to be indicated in cases in which the other hypnotics, either on account of their unfavorable action on the heart or respiration, on account of their taste, or for some idiosyncrasy of the patient, have to be reduced or stopped.

Vakulowsky (*Therapeutic Gaz.*, June, 1886) prescribed urethan in delirium tremens, rheumatic pains, sleeplessness (cause not stated), and in gastralgia due to carcinoma. In none of these cases did he find it comparable with chloral. On the con-

¹ *Therapeutic Gaz.*, July 15, 1886.

trary, he found it to produce gastric troubles in three patients, headache, rigidity of the muscles, and finally a marked weakening of the heart impulse and frequency. These cases, says the editor (*Russkaia Meditsina*, No. 14, p. 252), do not invalidate the claims of urethan, but they show the extreme variability of hypnotics.

A further note on the medicinal value of urethan has been presented to the Academy of Science, of Paris, by MM. Mairat and Combemale,¹ in which it is stated that this hypnotic is of value in cases of functional mental aberration in which there is not too much excitement; but where the mania is caused by organic alteration of the brain, it loses its effect after administration for from three to seven days, and the drug must be intermitted for two or three days.

Dr. Hans Rottenbiller (*Am. Jour. Med. Sci.*) communicates to the *Centralblatt für Nervenkrank.*, etc., No. 10, 1886, his experiences with the use of urethan subcutaneously. His observations were made on 14 patients, there being 240 administrations. Of these 14, 6 were imbecile, 1 senile dementia, 1 idiot, 1 chronic insanity, 1 epileptic, and 4 dementia paralytica. He began with seven and a half grains, but this had an effect on one only, a paralytic with wakefulness. In the other cases, with doses from seven and a half to fifteen grains, he obtained sleep for four hours, only the first few days; afterward, only one to two hours' sleep. From one dose of thirty to sixty grains, six to eight hours of tranquil sleep were procured in 8 patients. With 4 others (1 paralytic and 3 imbeciles), the same amount caused only two to four hours' sleep. In a case with intense maniacal excitement and lively hallucinations, urethan failed, and paraldehyde was resorted to with success. After receiving the injection of urethan, the patients fell asleep in fifteen to thirty minutes; some woke up in two or three hours, but remained quiet, and, perhaps, fell asleep again in a half-hour. There were no unpleasant after-symptoms, except vomiting in one case.

Dr. Wilhelm König (*Therap. Gaz.*) instituted a series of clinical experiments with urethan, and communicated the results obtained to the *Centralblatt für Nervenheilkunde*, June 15, 1886.

Urethan was exclusively tried on patients with a high nervous excitation; as for

lighter cases, remedies of a prompter and safer nature are more suitable, and hypodermic medication besides is a relatively inconvenient measure.

König abandoned the experiments on the seventh day, feeling convinced that in conditions of high-graded excitation the action of the drug, in doses safe and convenient to administer, was not sufficiently energetic to warrant its employment.

König also mentions that in nearly all patients who received the drug the appetite was found to be decreased on the third day. Other secondary effects, though, were not observed.

Mr. William Thomas Jackmann (*Lancet*, June 12, 1886) gives the following brief notes of a case of tetanus which recovered under the influence of the new hypnotic, urethan, in conjunction with chloral hydrate:

J. C., a lad aged fifteen years, came under my care on March 15, 1886. Fluid nourishment was administered and the chloral treatment continued until March 25th, when, as no abatement of the symptoms was apparent, after consultation with my partner, Mr. T. Simpson, it was decided to discontinue the chloral during the night, and in its place give the patient four grains of urethan every two hours, from 6 P.M. to 6 A.M. The first night of this treatment showed a marked decrease in the severity of the symptoms, and the patient made gradual and uninterrupted progress until April 20th, when his recovery was established.—*Four. Am. Med. Ass'n*, Aug. 28th.

Dr. William Carter has used the drug seven or more times. A case of sleeplessness following rheumatic fever it relieved. In a case of painful tubercular disease of the kidney it gave no relief. It caused heavy but unrefreshing sleep in a case of renal cirrhosis with an intercurrent attack of erysipelas. In a case of advanced cardiac disease with general dropsy, pulmonary engorgement, and very distressing dyspnoea, the drug had to be abandoned for morphia. In two cases of bronchitis its hypnotic effect was not noted, but the author is convinced that the drug diminishes expectoration.

Dr. H. B. Williams (*Four. Am. Med. Ass'n*, Jan. 22, 1887) used the drug only in insomnia of mania, and has found sleep result uniformly after the ingestion of the above-named dose.

¹ *Provinc. Med. Jour.*, June, 1886.

Dr. J. B. Andrews, Superintendent of the Buffalo State Asylum for the Insane, Buffalo, N. Y. (*Am. Jour. of Insanity*, Oct., 1886) performed upon himself some interesting experiments with the drug. In all of these experiments the sleep seemed to be of a strictly physiological character. Its approach was normal, and on awaking there was no headache nor any feeling other than that of having been aroused from pleasant sleep. There was no subsequent disturbance of the stomach of any kind, and, in fact, nothing to distinguish it from a pleasant period of repose.

In the pulse-tracings taken, he was unable to make out any marked change except a reduction in the number of the beats. The same observer administered the drug to eighteen patients.

On analyzing the cases we find that there were nine of women and nine of men. Divided as to forms of insanity, acute mania, 6; paresis, 4; melancholia, 4; chronic mania, 2; dementia, 2.

The dose most commonly given was thirty grains. In two instances, however, it was carried to the extent of sixty grains. This was ventured upon after personal experience with the same dose.

So far the results have been quite favorable, and show that urethan has marked hypnotic power. There were in no case any unpleasant results of any kind. There is nothing to indicate any further action than upon the cerebrum. The effects of the drug were felt within an hour after its administration, and the sleep lasted in most cases from the time of observation, commencing at ten o'clock, until five o'clock in the morning.

Collie (A.) on the Administration of Alcohol in Fever.—As a rule alcohol is not required in the mildest cases, nor in the severe if the patient be taking a sufficiency of food, nor generally in young adults of the well-to-do classes; but when food is not taken in sufficient quantity, in elderly patients, and in the case of poor and destitute children, it is more or less necessary, particularly in the latter. It is very useful in the case of adults, old and young, to produce sleep, and for young children it is especially useful for this purpose. The quantity to be given in any particular case must vary with a variety of conditions. Whilst no general rule therefore can be given, the writer may say that he has found the following to be useful

quantities: one bottle of champagne or one bottle of burgundy, half a bottle of port, or six ounces of brandy or whiskey, or ten ounces of gin for an adult daily. Children of course will require less in proportion.

Typhus Fever.—Alcohol is very rarely required for children in this fever, and it is seldom needed for adults under thirty, but as this age is passed it is required in a considerable proportion of cases, and sometimes in large quantity; but it may be dispensed with during convalescence very early, because the patient may generally have solid food as soon as the temperature has fallen.

Scarlet Fever.—In the great majority of cases alcohol is not required at any period of this disease; but in a considerable proportion of the children of the destitute poor it is indispensable, particularly during early convalescence, when there may be great weakness, when there are abscesses, swellings in the neck, particularly that form of swelling which has been called "brawny neck," with sloughing, and the best form in which to give alcohol in these cases is port. In some cases of dropsy gin will be used. It should in the writer's opinion almost always in the cases of children be preferred to opium to procure sleep.

Enteric Fever.—In this fever the chief value of alcohol is during convalescence. In cases of any severity the fever is long, and the consequent exhaustion great, the craving for food intense, and the dislike to milk and beef-tea very strong. Solid food in such cases cannot in the writer's judgment be safely permitted until from ten to fourteen days from the time the temperature has been normal throughout the day, and this is a trying time to a patient who has been on liquid food from three to four or five weeks. In these circumstances an allowance of some form of alcohol relieves the craving for food, favors recovery, avoids the danger from too early solid feeding, and generally makes life more tolerable. It is to be observed, however, that as a general rule alcohol is contra-indicated in cases of hemorrhage, except when the hemorrhage has resulted in collapse. Of the forms of the alcohol in this fever, the writer prefers burgundies and champagnes.—*Practitioner*. Nov., 1886.

Laparotomy in Wounds of the Abdomen.—At the annual meeting of the New York State Medical Association, held

November 16, 17, and 18, 1886, the discussion on gunshot wounds of the intestines was opened by Dr. W. S. Tremaine, of Buffalo, with general remarks on the usual treatment in such wounds adopted to within a short period. All were now agreed, he thought, that if it were positively known that the intestines had been wounded, the only course to follow would be to perform laparotomy, suture the rents, and properly dress the wound. The debatable point was whether or no laparotomy was justifiable to determine if, in a penetrating wound, the intestines were injured. He was in favor of such an operation, first, because the intestines may be wounded; second, it is in nine times out of ten required for the removal of effused blood; third, because the abdominal section adds little if any danger; to which may be added, fourth, the assurance given to the patient that his intestines have not sustained a fatal wound. Dr. Tremaine believes the operation should be done as early as possible, but believes the danger of delay and removal will be counterbalanced by placing the patient where the sanitary surroundings are good, and where skilled assistance and necessary appliances can be had.

Dr. Joseph D. Bryant, of New York, replied to the question, *What are the diagnostic signs of involvement of the intestines in shot wounds of the abdomen?* These signs will be local and constitutional. Among the former the position of the wound and its direction are of much importance, and if they indicate that the abdomen has been penetrated, the presumption is strong that the contents have been injured, though this is not always true. Hemorrhage from the wound, if not accounted for by the bleeding points found in the abdominal wall is conclusive evidence of intra-abdominal involvement. Bloody urine on bloody stools, passed soon after the injury, confirm the belief that may exist of visceral involvement. The escape of intestinal contents from the abdominal wound is very rare, but positive evidence when present. Tympanites developing slowly and with the appearance of pain and tenderness about the wound is due to gas in the intestines, while if it appear suddenly, before symptoms of inflammation, and if it be general, it indicates the presence of air in the peritoneal cavity. If normal hepatic dulness is replaced by tympanitic resonance, it is strongly diagnostic of even a small amount of air

in the abdominal cavity; but this sign might be produced by a distended colon pressing against the under surface of the liver, or by coils of small intestine adherent to the abdominal wall in this region.

Among the general symptoms, shock is the first to appear, and is present in varying degrees of prominence. If well marked it points to intestinal involvement. Third, restlessness and subnormal rectal temperature are all corroborative signs of perforation.

Dr. W. T. Bull, of New York, considered *under what circumstances, and how soon after the injury, should laparotomy be resorted to in shot wounds of intestine, and when is the operation indicated*, and expressed the belief that in case of bullet wound of the anterior abdominal walls, unless there be prolonged shock, which he considers a decided contra-indication, the original wounds should be opened and explored, first, to ascertain absolutely whether or no the abdominal cavity had been entered; and, second, to place the bullet wound in the best condition for healing. If the wound was found to be penetrating, the abdomen should be opened in the median line, the intestines carefully examined, and, any wounds found, sutured. Peritonitis, if present, would make the operation much more difficult, but was not considered a contra-indication if the general condition of the patient was fair. Removal of the intestines from the cavity for examination caused considerable shock and was not free from danger. Dr. Bull had followed this plan of treatment in three cases. Two of the patients recovered and one died.

In cases where the wound is situated in the posterior abdominal wall, or in the lateral wall covered by the ribs, and there is no wound anteriorly, he believes it would be proper to wait for symptoms before resorting to laparotomy, as there are many chances of the bullet being lodged in the muscles of the back or deflected by a rib.

Dr. John B. Hamilton, of Washington, in speaking of the technique, said that they did not differ from any other laparotomy. The intestines should be carefully handled, and kept covered as much as possible with towels wrung out in hot water. He had had one successful case and used fine catgut and the Lambert suture to close the intestinal wounds.—*Medical News*, Nov. 27, 1886.

In a discussion following a paper on *The*

proper treatment of penetrating wounds of the abdomen, read by Dr. H. H. Smith, at the Thirty-Seventh Annual Meeting of the American Medical Association, Dr. Watson, of Jersey City, said that if it could be determined that the intestines were perforated, laparotomy was demanded—that the difficulty was in making the diagnosis. The consent of the patient should be obtained, and the operation be thorough, and an exact and accurate examination be made to fully determine the damage done.

Dr. Gregory, of St. Louis, thought best to wait for urgent symptoms developed before operating.

Dr. Hamilton, U. S. M. Hospital Service, would not wait for dangerous symptoms, but if he believed the intestines had been wounded, he would operate at once.

Dr. Marcy, of Boston, thought the exploratory operation justifiable.

Dr. Yandell, of Louisville, thought the operation should be done at once, if at all. That he believed patients often died from wounds of the intestines without developing urgent symptoms.—*Four. Am. Med. Ass'n*, Nov. 27, 1886. G. B. PHELPS, M.D.

H. Gradle on Certain Diseases of the Vault of the Pharynx.—The importance of these affections, especially in their liability to lead to ear trouble, is not fully appreciated. The difficulty of posterior rhinoscopy is reduced by the use of cocaine, by using a large mirror, and in some cases by the aid of a palate hook, preferably one made of a loop of wire curved on the flat. Enlargement of the pharyngeal tonsil may be recognized by the finger passed behind the soft palate. It is frequently hypertrophied, from unknown causes, perhaps more often in scrofulous children than in others. The subjective symptoms, the alteration in the voice, and the reflex disturbances are familiar. The most common form of hypertrophy is not that which is generally described under the name "adenoid vegetations," but is a uniform diffuse enlargement. It shows a tendency to recede after maturity, and is seldom seen in adults. It can be treated only by surgical means. Frequent applications of the galvano-cautery are less satisfactory to the author than thorough scraping with the sharp curette, especially that recommended by Trautmann, which is so shaped as to be carried behind the soft palate to the edge of the vomer, and made to cut from before backwards and

downwards. Other forms of scoops are useful as adjuvants to Trautmann's instrument, for example, those cutting from side to side. Hemorrhage is very copious after the operation, but is readily controlled. Palpation shows whether the result is complete: Meyer's ring knife is objected to as being more disagreeable on the patient in its passage through the nose than an instrument introduced through the mouth. The galvano-caustic loop is difficult to apply. When the crypts of the pharyngeal tonsil contain white plugs, like those seen in the faucial tonsil, without special enlargement of the gland, the galvano-cautery is a very satisfactory agent.

In simple catarrhal naso-pharyngitis, without hypertrophy or visible lesion, the author prefers 4 % nitrate of silver solution, applied with brush or in spray, or insufflation of silver, one to six of talc. The prognosis is extremely unfavorable in these cases. In this connection the theory of Tornwaldt is referred to. This observer's suggestions were followed with some amelioration in about half the cases. The cysts, described by Tornwaldt, resulting from closure of the pharyngeal bursa, have been met with only twice. In each case the cavity was laid open and destroyed with the galvano-cautery, cure resulting.—*Chicago Med. Four. and Examiner*, Jan., 1887.

C. H. KNIGHT, M.D.

Contribution to the Study of Tornwaldt's Disease—Hypersecretion of Luschka's Gland.—Five cases of this affection are related by Luc. All were cured by galvano-cauterization, except one, which was an extremely aggravated case, and which was, nevertheless, benefited to a considerable degree by the treatment. This disease should be suspected in all cases of chronic pharyngitis characterized by dryness of the walls of the pharynx and collections of crusts and mucus. Vigorous galvano-cauterization of the pharyngeal bursa cures the catarrh and leads to a disappearance of the secondary pharyngitis. The existence of symptoms of true ozæna is no contra-indication to interference with Luschka's gland, since destruction of the gland would tend to improve the condition of things by lessening the accumulation of secretion in the cavity. As a rule, the author prefers, in posterior rhinoscopy, to use a large laryngeal mirror and a Voltolini hook.—*France Méd.*, Nos. 120 and 121, 1886.

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THERAPEUTICS.

Robin (A.) on the Oxidizing Method in the Treatment of Fevers, and Particularly Typhoid Fever.—The chemical state of nutrition in typhoid fever convinces the author that the elevation of temperature does not depend on the increased oxidation of organic matter; that during the fever there is a retention in the organism of waste products which are almost insoluble, of difficult elimination, and habitually toxic; that organic change is much augmented during fever.

The author considers that there are two great therapeutic indications: First, to eliminate from the treatment all methods and medicaments which slow oxidation. Under this head would come nearly all the antipyretics now in use. His second indication is to favor by all possible means the oxidation process which will diminish the formation of extractions, ptomaines, and leucomaines, and which will at the same time aid in their elimination and oxidation, rendering them more soluble and less toxic. The means he suggests to bring about this state of affairs are: first, to furnish plenty of cool fresh air to the patient, if necessary oxygenating it or giving inhalations of oxygen; second, to maintain the lungs, as the passage of entrance of oxygen, in as perfect a condition as possible; third, to stimulate the nervous centres, regulating the oxidation process, by spongings and cold baths; fourth, to select among medicaments such agents as augment the process of oxidation.

He advises alcohol in small doses, common salt, alkalies, salts of organic acids, and abundant drinks. The salicylates do not retard oxidation, but lower the temperature by rendering soluble and hence eliminating waste products.—*Gaz. Méd. de Paris*, Dec., 1886.

Brin on Oxygen in Therapeutics.—The two great difficulties which have opposed the use of oxygen on the very threshold have been the cost of its production and its impurity when produced. The anhydrous oxide of barium, placed in retorts heated to a given temperature, and served with a supply of purified atmospheric air, will give off every two hours oxygen at the rate of one cubic foot per pound of barium oxide. Perhaps the most interesting point in connection with this process is that it is absolutely a mechanical one.

There is no loss or waste of the agent employed—namely, the anhydrous oxide of barium. There is no visible difference under the microscope between the low and the peroxide, and no chemical change takes place. The oxygen is absorbed from the purified air passed through the retorts under pressure; it is given off again under vacuum; and the proof that in carrying out this method MM. Brin call to their aid no complex chemical decomposition is, that the same pound of barium, increased in weight when it takes up the oxygen, returns to its exact original weight when, under vacuum, the oxygen is yielded up. Moreover this same pound of barium is at once ready to perform, and repeat *ad infinitum*, its task of absorbing and yielding up this perfectly pure oxygen.—*Lancet*, Dec. 18, 1886.

Meunier (A.) on Rendering Antiseptics fit for Injections.—The author has used vaseline as a vehicle for different antiseptics, such as creosote, eucalyptol, iodoform, santal, etc., and various alkaloids. This method has been employed with great success by Bouvert and Durand.¹ Durand has also administered the bisulphide of carbon in the same way.

The only precaution to take is to use a pure vaseline. The solution, if such it can be called, is useful as a surgical dressing, as a local application to accessible viscera or organs, and as an injection mass for sinuses, fistulas, hypodermic or parenchymatous injections.—*Lyon Médical*, Jan. 2, 1887.

Charrin on the Action of Naphthaline.—The author has found that after giving gr. xxv. to xxx. of naphthaline a day to rabbits, on the twentieth to the twenty-fifth day cataract appears. If the drug is stopped, the progress of the lesion ceases; if it is recommenced, the lesion progresses. Naphthol and analogous preparations have no such effect.—*Gaz. du Hôp.*, Jan. 4, 1887.

Duval (P. P.) on Opium and Camphor Reciprocal Antidotes.—I have found that fifteen to twenty-five minims of the oil of camphor are sufficient to neutralize in a short time the toxic effect of half an ounce of laudanum of more than official strength, removing quickly, in sufficient dose, coma, stupor, and narcotism, and

¹ Balzer, following the method of Scarenzio, has treated syphilis by subcutaneous injections of calomel suspended in glycerine.—*Le Courrier Médical*, Jan. 8, 1887.—Ed.

leaving the patient in a harmless state of sleepy wakefulness, which lasts for a length of time corresponding to the quantity of the opiate taken. The antidote should be given in broken doses in quick succession, as it acts promptly, especially if the quantity of opium taken is uncertain. I have made it a rule not to give more camphor than to produce the condition I have described above, although aware of the fact that opium would antidote the effects of the camphor, if, by accident, given in such quantity.—*Virg. Med. Mo.*, Jan., 1887.

Stas (J. S.) on Absorption of Medicaments by the Skin.—Dilute solutions of sodium arseniate and iodide of potassium are not absorbed, when the skin is sound, by daily baths lasting an hour and a half. The iodine of the tincture of iodine applied to the sound skin does not penetrate the body. Some absorption takes place after the destruction of the skin by the iodine and its consequent fixation upon the derma. In this case it is eliminated in part by transpiration from the iodized surface, partly the kidneys, and lastly, but in a very small amount, from the rest of the body.—*L'Union Méd.*, Dec. 23, 1886.

Federoff, in a St. Petersburg thesis, narrates similar experiments with the iodide of potassium and the hydrochlorate of lithium. The author draws the following general conclusion: "The intact normal human skin does not absorb any fixed substances dissolved in water and pulverized by a spray-apparatus; neither the concentration of the solution, nor the temperature of the skin, nor the strength with which the pulverized jet plays, shows any influence whatever, so long as they remain within limits compatible with the integrity of the integuments."—*Lond. Med. Record*, Dec. 15, 1886.

Turnbull (L.)—Is Chloroform More Dangerous to Animal Life than the Bromide of Ethyl?—He, in conjunction with his friends, had made a number of experiments on the sedative effect of chloroform upon the heart's action and the reflex phenomena, on irritation of the sensory filaments of the fifth nerve, thereby showing that a small dose of chloroform is much more dangerous than the bromide of ethyl, when the heart power is most seriously reduced by its action, and is incapable of supplying the brain properly, unless the patient is in the recumbent posture.—*Med. and Surg. Reporter*, Jan. 22, 1887.

Palasne de Champeaux on the Use of Bisulphide of Carbon Water in Fetid Diarrhœa.—The author reports, in the *Arch. de Méd. Navale*, two recoveries from diarrhœa in Cochin China, remarkable by reason of the severity of the cases, and because of the unique disinfectant treatment employed. An ounce of pure bisulphide of carbon is put in a bottle with thirty drops of peppermint essence, and upon this is poured sixteen ounces of water.

Of the supernatant fluid, one to two ounces are taken daily in spoonful doses, and as the mixture is taken out the bottle is refilled with fresh water. The improvement may not be sudden, but in three or four days the stools cease to be fetid.—*Four. de Méd. et de Chir. Prat.*, Jan., 1887.

Huse (R. C.) on Ice-Water Enemata.—I first used it in a case of prolapse of the rectum in acute dysentery, curing both troubles in a short time. This was a soldier in the service in 1863. In 1868, in a case of acute hemorrhoids, with prolapse of the rectal mucous membrane from acute diarrhœa, ice-water relieved all the symptoms more rapidly than any other treatment of which I am cognizant.

Especially valuable evidence is a case of acute procerdentia of the rectal mucous tissue in a case of intercurrent dysentery in a patient two years of age, undergoing treatment by aspiration for an acute empyema after "measles." Here the pain from the rectal troubles was threatening collapse, coupled as it was by frequent dejections which were not relieved by opiate enemata and saline cathartics. Recourse was had to ice-water enemata after each defecation, with the most gratifying results as to pain and frequency of the discharges. The livid mucous surface, as it became chilled, was blanched in appearance, and the procerdentia, or intussusception, was restored to its normal condition without any other aid.—*Therap. Gaz.*, Jan. 15, 1886.

Foy (G.) on Aspiration of the Stomach.—I was called to see a man who was reported as dying from drink. I found the man lying dead drunk, from having taken a very large quantity of claret and whiskey. The man was totally devoid of sensibility, his extremities were cold, his face livid, the pupils widely dilated, respiration hardly detectable, no pulse, and the heart impulse hardly to be felt.

I commenced the treatment by opening the median-basilic vein of the left arm, and

by rubbing the forearm briskly got some ink-black blood to flow, and did not stay the bleeding until about sixteen fluid ounces had been taken. Whilst the arm was bleeding I pushed the fine trocar of an aspirator through the abdominal wall in an upward, backward, and outward direction from its point of entrance at the sternal end of the eighth rib. The cannula was attached by the ordinary method to an exhaust bottle, and on turning the cock I was pleased to see a stream of claret-colored fluid. The heart commenced to beat; the blood stream from the arm became arched and more full; the pulse was now easily felt; respiration recommenced; and I withdrew the cannula, not wishing to empty the viscus by the aspirator, lest it would slip off the tube, which was shorter than I would have wished. With a stomach-pump I now washed out the stomach, and soon afterwards the man was able to speak. He was put into a warm bed and the next day was sufficiently recovered to go home.—*Dublin Four. Med. Sci.*, Jan., 1887.

Fordyce (B. A.)—Something Old and New in the Treatment of Acute Dysentery.—The inflamed œdematous condition of the mucous membrane, and consequent obstruction to passages from the bowel, in this disease is well known. Remembering the relief often obtained from hot water to inflamed surfaces, and the beneficial effects of solutions of bichloride of mercury upon ulcerated surfaces, particularly of mucous membrane, the thought occurred to me that if I could carry the hot water into the bowel, allowing it to flow back in sufficient quantity to remove for a distance from above all fecal and offending matter, I should accomplish two important objects—*i. e.*, relief of pain, and prevent absorption of poisonous matter into the blood, the antiseptic properties of the bichloride aiding in this latter object. Upon this I acted, using a soft rubber tube attached to a Davidson's syringe, passed carefully through this sensitive inflamed tissue, so as to carry the liquid above the rectum into the colon. The patient was placed on his side, with an oil-cloth beneath him, and four or five quarts of water as hot as could be borne were injected and allowed to flow back with whatever substance had accumulated or remained in the bowel above. When the water returned clear,

then a quart or more of the solution of bichloride, about 1 to 10,000, was injected and allowed to return in the same manner. The effect was immediate relief of pain and tenesmus. A suppository of opium, one grain, was given and retained, and, for the first time after the attack, the patient slept seven hours, awaked refreshed, could take some food, and, if perfectly still, was free from pain. In about twelve hours slight return of pain was felt, and the same treatment repeated. This treatment was continued, with the bichloride solution, four times, and the hot water alone was used for four or five days more, with suppositories of one half grain opium, morning and night, with perfect recovery, no medicine being administered by the stomach, except one-grain doses of quinine, three times per day.—*Buffalo Med. and Surg. Jour.*, Jan., 1887.

Huault (A.) on the Use of Benzoate of Soda in Some Catarrhal or Congestive Affections of the Upper Air-Passages.—The author thinks that the benzoate of soda seems to have a special predilection for the upper air-tract, analogous to the peculiarities of other balsams, as terpene affects the bronchial and turpentine the genito-urinary mucous membrane. He considers it indicated in common cold in the head, acute inflammatory angina, simple, chronic coryza, and congestive growths similar to granular sore throat.

The remedy should be given in doses of from one to two drachms for from six to twelve days. Remissions in the administration of the drug are necessary to avoid causing an aggravating digestive trouble.—*La France Méd.*, Jan. 1 and 4, 1887.

Sprimon on Tincture of Benzoin in Nasal Catarrh.—In the *Médiz. Obsr.*, No. 3, 1886, p. 295, Dr. V. F. Sprimon, the editor, fully indorses the statements of Keibell (*Brit. Med. Jour.*, Feb. 28, 1885, p. 430) and Brydon (*ib.*, March 28, p. 682) concerning the high value of tincture of benzoin as a remedy for common nasal catarrh. The author advises, however, not only to inhale, but also to paint the nasal membrane with, the tincture.—*London Med. Record*, April 15, 1886.

Poulet (V.) on Some New Facts Concerning the Treatment of Asthma by Oxalic Acid.—The author claims that the unpleasant effects that have been seen to follow the administration of oxalic acid are the results of a too concentrated

solution of the drug. He asserts that gr. xxx. doses are harmless if taken in eight ounces of vehicle. He lays much stress on its sedative powers whether it is administered as an anti-dyspnoëic, emmenagogue, or in strangulated hernia. Under such circumstances the accelerated pulse and elevated temperature both fall.

In apyretic conditions, in addition to checking the spasmodic conditions, for which it is given, it restores the temperature to normal, acts as a sedative to the pulse, and regulates the breathing. He reports two new cases, showing the beneficial effects of the drug—one, what he calls a case of dysmenorrhœic asthma; the other a case of bronchial asthma, occurring during the puerperal state. Both were cured by one dose of the drug.—*Bull. Gén. de Thé.*, Dec. 30, 1886.

Treatment of Chorea.—In the earlier years the fluid extract of *cimicifuga racemosa* was always relied upon and administered as soon as the patients presented themselves. Experience has emphatically taught us, however, that it is distinctly inferior to arsenic; so that at present every patient coming to the dispensary with the St. Vitus' dance is put upon the arsenical treatment. In the few cases in which this fails, the next routine administration is of the fluid extract of *cimicifuga*. We can only explain the superiority which *cimicifuga* has asserted over arsenic in the hands of Dr. Corson, by the supposition that the doctor has never used arsenic with sufficient freedom.

The arsenical preparation must be given in ascending doses until it produces evidences of its physiological action, and to order this requires a little boldness on the part of the physician. If, however, the patient be well watched and the remedy be withdrawn as soon as puffiness appears in the face, no harm can be done. *Cimicifuga* is not an inert substance, as seems to be thought by some practitioners. Probably much of the *cimicifuga* that is administered has lost its activity, which appears to depend upon a volatile principle. But we have seen a teaspoonful of the good fluid extract, even in an adult, produce headache, with excessive giddiness and great prostration.

We may add that when, some years ago, the bromide of iron was highly recommended by Dr. Da Costa in the treatment of chorea, we made an extensive and thor-

ough trial of it, and found its therapeutical action as near negative as we can well imagine. In a number of cases it simply did no good at all.—*Therap. Gaz.*, Jan. 15, 1886.

Pardington (G. L.) on Massage in Migraine.—The case in which this treatment was employed was a man of twenty-six. The attack comes on usually in the evening, and is characterized by feelings of oppression, faintness, and giddiness, accompanied by shivering, cold, and inability to speak, together with twitchings of the muscles of the face and limbs on the left side, and violent pain over the whole of the left side of the head. The doctor determined to try massage, and ordered him the treatment for twenty minutes night and morning, beginning with gentle friction, and ending with thorough kneading of the parts with the tips of the fingers in the manner known as *pétrissage*, the manipulation to be confined to the scalp and muscles of the neck on the affected side, all medicines to be omitted.

In three weeks the patient seemed entirely relieved but he was then lost sight of.—*Practitioner*, Dec., 1886.

[Dr. Geo. W. Jacoby of N. Y. has advocated this treatment of massage, and a brief abstract of his paper may be found, *MEDICAL ANALECTIC*, 1886, p. 303, ED.]

Wilson (J. R.) on the Place of Quinine in the Therapeutics of Typhoid Fever.—In the Catskill Mountains, where they have the true typhoid fever, my experience was that typhoid fever could not be averted, or its natural course shortened, by large doses of quinine; that other than tonic doses harmed; that any preventive other than plenty of fresh air, bathing, and supporting treatment was hurtful. We could tell typhoid fever by the symptoms, not by finding in the blood and dejections the result of diseased conditions—a typhoid bacillus, as I think they call it.—*N. Y. Med. Record*, Dec. 11, 1886.

Wiggins (G. A.) on the Use of Digitalis in Combination with Bromides in Epilepsy.—The author recommends digitalis, in conjunction with Brown-Séquard's prescription, as worthy of careful consideration and trial in a disease which sometimes requires all our resources to control.—*Med. Times*, Dec. 11, 1886.

Viper Poison and Rabies.—A writer in *Los Avisos* mentions that a dog

which had been several times severely bitten by different rabid dogs, and had shown no symptoms of rabies itself, had been previously twice bitten by vipers, and suggests the possibility of the poison of the viper having conferred an immunity from rabies. Dr. Fernandez, of Barcelona, has carried the idea a step farther. He has made a number of experiments, and established that dogs may be rendered refractory to rabies, either spontaneous or after a bite, by inoculation with viper poison. He has inoculated dogs for five days, they experienced fever and other symptoms, which passed away, rendering the dogs refractory. This is the newest discovery of science.—*Provin. Med. Four.*, Jan. 1, 1887.

Drysdale (A.) on Crotalus or Rattlesnake Poison; its Sphere of Action and Usefulness.—The venom contains: an albuminous body, crotaline, not coagulable at 212° F.; an albuminoid coagulable at 160° ; coloring matter and extractives soluble in alcohol; and fatty matters, chlorides, and phosphates. The virulence of the venom is completely destroyed by bromine, iodine, bromehydric acid, caustic soda and potash, and also permanganate.

Medicinal Form.—One part of the pure crotalus venom to nine parts of glycerine; this will keep any time, and may be diluted to the extent desired.

The main application of this remedy is in the pernicious fevers, where the whole mass of the blood is vitiated, probably as a consequence of the diminution or loss of vitality of the protoplasm composing the leucocytes. This condition, known as "the typhoid state," whether supervening upon a continued fever, pneumonia, or mere senile asthenia, is well and successfully treated by drop doses of solution of crotalus, 1 in 100, repeated every two hours. Most medical men have met with a condition of body, usually at the end of an organic complaint of long standing, such as Bright's disease, phthisis, mitral disease of the heart, etc., but sometimes merely from age added to want or deficiency of essential ingredients of the food even in young people. Such a condition, whether following upon organic disease or due only to insufficiency or improper quality of the food (scurvy), is well treated by drop doses of crotalus solution (1 in 100); the blood is gradually brought to a healthy condition, where this is possible, and in other cases

amelioration and prolongation of life may be confidently looked for. That form of Bright's disease which is a sequela of scarlet-fever and other exanthemata is often benefited by crotalus. A certain form of headache—not severe in degree, and not increased by shaking or sudden movement of the head—usually present in persons of languid constitution and sedentary habits, and often accompanied with relaxed sore throat, has received much benefit from the drug where it has been impossible to remove the cause, *i.e.*, a relaxed condition of the system. It will be seen that crotalus is one of those substances which, though producing extremely violent effects in large quantities, has little effect in comparatively small doses, and, apparently, has little preference for individual organs; in this it resembles prussic acid, and is unlike most other violently acting poisons, such as arsenic, which has a distinct elective affinity for the skin and stomach, or phosphorus, which selects the lungs and nervous tissues. Its sphere of usefulness must be looked for therefore among the graver maladies, where the whole blood mass is affected, rather than in slighter and more localized ailments.—*Med. Press*, Dec. 8, 1886.

Sawyer (J.) on the Use of Guaiacum as an Emmenagogue.—I have given guaiacum in a large number of cases of amenorrhœa, with results which, in the main, bear out the observations and conclusions of Dr. Cleland.¹ My experience in the use of guaiacum as an emmenagogue has led me to regard that drug as a remedy in promoting the menstrual secretion in a large proportion of cases of amenorrhœa. It appears most efficient, when given alone, in those cases in which the cause of the amenorrhœa is obscure; that is, in those cases in which there is no obvious spanæmic deterioration to which the menstrual deficiency is referable. I give ten grains of the powdered resin of guaiacum, stirred in a wineglassful of milk, every morning, before breakfast. The remedy may thus be given safely for some weeks. In a few instances, I have found it to be necessary to suspend temporarily the administration of the drug, on account of the production of a little abdominal pain and purging.

I have often verified the curative efficacy

¹ See also *British Medical Journal*, June 7, 1873.

² *Irish Hospital Gazette*, Jan., 1873.

of guaiacum in some cases of dysmenorrhœa. In those cases of dysmenorrhœa in which we can find no vice producing menstrual obstruction of a mechanical nature, and in which there are no local inflammatory or plethoric signs, the ammoniated tincture of guaiacum is a reliable remedy when given during the painful period. I direct a dose of from half a drachm to a drachm, to be taken in a wineglassful of water, every two or three hours, until the pain is relieved. I find the following reference to this employment of guaiacum in Dr. Pereira's *Materia Medica*: "*In obstructed and painful menstruation*, not arising from any plethoric, inflammatory, or congested state of system, the ammoniated tincture of guaiac has been employed with advantage."—*Birmingham Med. Rev.*, Jan., 1887.

Garrigues (H. G.) on Cotton Root as a Uterine Hæmostatic.—I have been particularly surprised in watching its action on different growths. In fibroids it not only checks the hemorrhage, but has a marked effect in relieving the concomitant pain. Nay, even in sarcoma and carcinoma, I have seen its unmistakable influence in limiting or altogether suspending for weeks at a time the loss of blood.

First my attention was called to the fluid extract, but I found it almost ineffectual unless given in such large doses that it upset the stomach. I therefore discontinued it, and directed the patients to prepare for themselves a decoction every morning by boiling three heaping teaspoonfuls of the powdered root in a pint of boiling water for a quarter of an hour. It should then be strained and allowed to cool. Of this cold decoction they drink one third in the forenoon, and the same quantity in the afternoon and at bedtime. It is of a pink color, much like raspberry lemonade, and has a not unpleasant, aromatic, and slightly astringent taste. One hundred and thirty-nine patients were treated with this decoction. I allowed them to continue using it for several months. At the time of the menstruation I discontinue it for from two to four days, according to the amount of blood lost.

Besides being a hæmostatic, it has a general tonic effect, which is so much the more valuable as chalybeates are contra-indicated, iron in any shape taken internally increasing the flow which it is the first indication to arrest.

I consider, therefore, cotton root to be an exceedingly valuable drug in gynæcological practice; but if the reader should feel inclined to try it, he must insist on the patient using the freshly-made decoction, and he must not forget that I have expressly stated that in a certain number of cases, say about one in ten, it has no power. There is hardly any doubt about the great efficacy of the fresh bark of the root in producing abortion, whereas I know of cases where even a very strong decoction of the old bark has been used in large doses by pregnant women without any effect; and the hæmostatic effect is probably due to the same cause as the ecbotic, namely, to the production of uterine contraction.—*Quarterly Bulletin*, Jan., 1887.

Saundby (R.) on the Action of Drugs in Albuminuria.—I have used alkalies in the form of diluents—for example, bitartrate of potash, or Vichy water, and in a series of chronic cases, with persistent and copious albuminuria, the results were distinctly favorable. In addition to these diluents, I have employed citrate of lithia, bicarbonate of potash, and benzoate and bicarbonate of soda, and include them in this favorable opinion. In the following five chronic cases, the average total amount of albumen passed on the first and last two days of the experiment are given:

Name.	First Two Days.	Last Two Days.
B.	38 grs.	21 grs.
R.	38 grs.	13 grs.
J.	123 grs.	64 grs.
McD.	52 grs.	48 grs.
St.	16 grs.	21 grs.

I found tannate of soda so nauseous that I have used in its stead the following formula:

℞	Acidi tannici, sodæ bicarb.	52 gr. x;
	Glycerini	℥ xv;
	Aquæ	℥ j.—M.

I can report in relatively favorable terms of it. For example:

Name.	First Two Days.	Last Two Days.
M.	108 grs.	150 grs.
J.	165 grs.	96 grs.

These were both chronic cases. In an acute case I got good results, but the influence of the drug was very doubtful here:

Name.	First Two Days.	Last Two Days.
Be.	22 grs.	11 grs.

■ I have seen cases do remarkably well under the use of nitro-glycerine; but I am

not able to confirm this by exact observation, except in acute cases.

<i>Name.</i>	<i>First Two Days.</i>	<i>Last Two Days.</i>
Be.	26 grs.	10 grs.

In a chronic case I found :

<i>Name.</i>	<i>First Two Days.</i>	<i>Last Two Days.</i>
McD.	40 grs.	43 grs.

Under the most favorable circumstances I have been unable to observe results which bear out the reputation fuchsin has acquired.

I have used it in a very large number of cases, and I have never seen any good effected by it.

Digitalis appears to increase the amount of albumen, and this holds good of other heart-tonics, for example, caffeine, strophanthus, and sulphate of sparteine. Iron, including the acetate, sulphate, and perchloride, have the same effect of increasing the albumen. The bichloride of mercury has had a fair trial, but has entirely failed. Purgatives and diaphoretics, though of great value in its treatment, do not appear directly to influence the amount of albumen excreted in chronic Bright's disease.

I give the results of twenty-one cases recently under my care. Of five acute cases, two left the hospital much improved in health, with a good deal of albuminuria, but no dropsy; two had a faint trace of albumen, but no dropsy; one neither albumen nor dropsy. Of two subacute cases, both left with the albumen reduced to a cloud, and no dropsy. Of fourteen chronic cases, five died, four did fairly, and five did well. It would be foolish in the extreme to direct our treatment exclusively to one symptom, which certainly is of no great importance in itself, or to measure our success solely by that standard.

The injurious effects of prolonged albuminuria have been greatly exaggerated, and while improvement in the condition of the kidneys is generally accompanied by diminution in the loss of albumen, this may continue to persist for years, even in relatively large amount, without injury to health, and with fair performance of the renal functions.—*Br. Med. Jour.*, Nov. 27, 1886.

Wilcocks (F.) on Large and Small Doses of Iron in Anæmia.—Large doses of iron, as Bland's pills, ferrum redactum, and the like, simultaneously increase both the number and the hæmo-

globin value of the red globules in the blood; the influence of small doses, on the other hand, is directed mainly to the increase in the number, the average hæmoglobin value of the individual corpuscle remaining constant, or even undergoing diminution at first. On the smaller dose of iron the process of repair more nearly resembled the natural mode of blood-regeneration, as after hemorrhage when the increase in the number of the corpuscles precedes their rise in physiological value.—*Brit. Med. Jour.*, Nov. 13, 1886.

MEDICINE.

Debove (M.) on Diagnosis of Cancer of the Stomach by Chemical Examination of the Secretions of that Organ.—The author, taking into account the difficulty often surrounding the diagnosis of gastric cancer in its early stages, has tested the statement, repeatedly made by German physicians, that during digestion there is no free hydrochloric acid in the gastric juice if cancer of the stomach be present. He has tested the gastric juice during digestion in various non-cancerous ailments, and finds free hydrochloric acid always present, but in all the cancerous cases it has been absent, lactic acid taking its place. He does not think such will invariably be the case, but as far as his experience goes it has always been so.—*Gaz. Hebdom.*, Dec. 31, 1886.

Wilson (J. C.) on a Case of Peritonitis in Enteric Fever, Terminating in Recovery.—The patient was a girl of twelve. Defervescence began about the middle of the third week. On the seventeenth day the morning temperature was normal, and on the twenty-first defervescence was complete. No solid food was permitted until the twenty-third day. A soft-boiled egg, into which was stirred a little finely crumbled stale bread, was given about 11 A.M. Half an hour later the patient complained of severe pain in the abdomen, and had a chill, which was followed by vomiting. At 7 P.M. I saw her. The vomiting had ceased, but there was intense nausea, with thirst; the tongue was dry; the belly tense and tender; the pulse small, tense, and 140 in the minute; decubitus dorsal, with knees drawn up; the axillary temperature was 104.5° F. There were not at this time, nor could I find

upon careful questioning, that there had been any sign of collapse after the chill. Two hours later Dr. W. W. Keen saw her with me. The temperature had fallen a degree, and the pulse to 120. Upon palpation the whole belly was exquisitely tender, but we both thought that the focus of tenderness was in the right iliac fossa. The pain was general over the abdomen.

The treatment consisted of half a grain of opium by suppository every six hours, and forty drops of paregoric every two hours. The belly was smeared with equal parts of sweet oil and turpentine and covered with a light poultice. A little iced whiskey-and-water from time to time was allowed, but nothing in the way of food was permitted during the night. Light liquid food was prescribed and retained. From this time catheterization was necessary for several days. The urine contained a trace of albumen and a few hyaline casts. Nine days later deferescence, which was gradual, was complete.

At the expiration of three weeks recovery seemed to be complete; yet on two occasions within the last month a larger meal than usual has been followed by fever, lasting two or three days, and by tenderness in the right iliac fossa. For the past two weeks the patient has been apparently in her usual health.—*Med. Times*, Dec. 11, 1886.

Jewell (J. S.) on Overfilling and Dilatation of the Colon, and Some of their Local and Remote Effects, with Particular Reference to Some of their Relations to Disorder of the Nervous System.—It has been of almost daily occurrence for persons to reply, in answer to the query if they were costive: "*No, doctor; I am not. I am as regular as clock-work. I have a movement from the bowels every morning.*" Such an answer has been often given me, even by physicians themselves, when, as patients, they have been giving the history of their own cases. In the vast majority of this class of cases, not to speak of those in which the patients described themselves to be costive, I have found upon examination, the colon to be more or less filled, certainly to an unhealthy degree, with fæcal matter. My common mode of examination has been to direct the patient to lie down on the back. The abdomen is then laid bare, or, if not, is left covered

only by a thin underdress, and is then carefully inspected as to its size, and comparative proportions with other parts of the trunk and the limbs of the patient, and as to its fulness, especially below the level of the umbilicus, and at the sides, at the level of the loins. I then take a soft, dark rubber eraser from one-half to three-fifths of an inch in thickness, two or two and one half inches in length, and one to two inches in breadth. Next, I provide myself with a rather heavy steel hammer, such as is used in connection with the bone chisel in surgical operations. The patient is directed to leave the abdomen relaxed, and the examination is begun, generally over the lower extremity of the ascending colon. The rubber plate is first pressed with moderate firmness over the part, and strokes with the hammer, varying in force, are made at various points along the entire length of the portion of the intestine in question. Then the rubber is pressed firmly but slowly, until it rests (with nothing but the intervening wall of the abdomen) upon the more solid contents of the same. The same process of percussion is gone through with, at all points carefully observing the percussion note. The same process is carried along the course of the descending colon, from near the spinal column, as high up as the level of the last rib, down deep into the left inguinal space. Palpation is then made, lightly at first, so as to avoid contractions of the muscles of the abdomen, until the whole cavity has been explored by percussion, palpation, inspection, for any unusual conditions, whether relating to fæcal masses, tumors, or growths of any kind, soreness or tenderness, etc., to the end. But by these means I have been able to discover, in an astonishingly large proportion of cases, even where the patient was declared to be "as regular as clock-work," greater or less degrees of abnormal fulness of the colon, and, in some instances, never suspected until ascertained by such an examination as has just been named, enormous quantities of fæcal matter, evidently detained for weeks, or even months. The longest period of detention of a fæcal mass in the colon that has fallen under my own observation, with clear proofs of the length of the period named, was about nine and one half months. I am speaking now, of course, of persons who have consulted me *on account of ill health*. But I have extended my ob-

servations, and with care, since I became deeply interested in this subject,—from my patients to persons ordinarily counted healthy, and to those suffering, and, in a large proportion of the so-called healthy, I have found more or less overdistention of the colon. I have almost invariably found it so in the case of individuals who have had from time to time what have been called, in the most vague of vague language, “bilious” spells; the so-called “biliousness” being found generally to depend not upon disorder of the “liver,” as is so commonly supposed, and the term referred to implies, but upon gradually accumulated fæces, and the many bad results to which this condition directly and indirectly leads. An amount, variable in proportion to total mass actually present, may be passed away daily, or washed away, as it may be said, by a saline purge. But more or less (generally more) remains, until at last the irritation of the colon, distention of the abdomen, the consecutive disorder of the stomach, and of the digestive tube throughout, the absorption of various poisonous products (ptomaines) from the fermenting fæces, not to carry the list of bad consequences farther, plunge the patient into what is called a “bilious” attack, or, less commonly but worse yet, into a typho-malarial fever, if nothing more. Doses, more or less large, of purgative pills, are then taken, followed often by powerful saline cathartics, and so on to the never-ending end; and, on each occasion, after one or more days of wretchedness, the patient is found better; pretty soon, it may be, recovers; and then for a month or so, but differing in different cases, is comparatively well again. Patients, and even physicians, begin to sniff around for “malaria,” or “sewer gas,” or it may be something else. Meanwhile the patient carries within the abdomen, and in contact with an absorbent surface, decomposing, often extremely offensive, and quite as often poisonous, fæcal substances, portions of which are absorbed by the mucous membrane, in contact with which these materials lie, and are thus introduced, from a plain source, and in a natural way, into the blood; and, once in it, they are carried throughout all parts of the body.

The wonder is, not that people become ill under such conditions, but that so many persons escape with such comparatively slight bad results when once the phenomena

are connected with their true causes.—*Neurological Review*, Nov., 1886.

Cheadle (W. B.) on the Pathology and Treatment of Chronic Constipation in Childhood, and its Sequel, Atony, and Dilatation of the Colon.

—In children the question of constipation is in certain aspects very serious, for it affects not only present health and comfort, but future development and the working conditions of the alimentary canal for the whole of after-life. There is this difference, further, between the two cases: Injudicious treatment may render constipation confirmed in the case of the adult. In the case of the child it may do this also, but it may do far more, as I shall show presently. It may, and often does, cause such serious injury to the bowel itself that it recovers only after long and careful management, even if the damage inflicted be not permanent and incurable. As a general proposition, it may be said, perhaps, that adults suffer most from the consequences of neglect of constipation, children from the too vigorous and mischievous treatment of it. The treatment of constipation in childhood, then, is a subject of considerable importance. To be successful it must comprise something more scientific and comprehensive than the mere administration of aperients. It is not enough to open the canal when blocked, or sweep it clear of accumulations which have lodged there. The essential point is to establish such a habit of daily evacuation that accumulation of the noxious waste and its evil consequences may not recur—to modify the condition permanently. In order to do this the causes which give rise to it must be thoroughly understood—must be removed, or neutralized, or compensated.

There are many different factors concerned in the production of constipation, which act in varying degree in different cases. 1. Deficient fluid in the intestinal canal, caused by deficient supply in food, excessive waste, or deficient secretion from the intestinal mucous membrane. 2. Deficient peristalsis, especially of the large intestine, from defects of diet, or from atony due to over-stimulation by purgatives or to degeneration of the muscular coat. 3. Inhibitory influences of the nerve centres of the brain and cord, probably affecting both peristalsis and secretion of fluid. 4. Deficient bodily exercise and movement. 5. Dilatation of the intestine, especially the

colon, due to debility of the intestinal wall or to actual dilatation by accumulated fæces, gaseous distention, repeated enemata, or laxness of the abdominal wall.

Such are the chief causes which give rise to constipation. They are not all met with in the case of children, however—at least not in equal degree. Thus, weakening of the muscular fibre of the intestine by the deterioration of age, mental depression, deficient bodily exercise, or astringent food rarely can be credited with the production of deficient peristalsis in early life. Putting aside malformation, such as atresia more or less complete, peritonitis, intussusception, and the like, the causes which are chiefly operative in childhood are: 1. Food which leaves little residue; very completely digestible food—*e. g.*, milk: fæcal matter too small to duly excite peristalsis. This is a common cause in very young children, and in like manner a too great uniformity of food fails to excite peristalsis. 2. Deficiency of liquid in food, not enough to drink, is another not infrequent cause in children: causing too dry fæces. 3. Deficient biliary secretion, “acholia”: unstimulating fæces. 4. Deficient secretion of glands of mucous tract: dry fæces. 5. Over-stimulation and consequent atony of intestine: loss of excitability and loss of power, caused—(*a*) by coarse foods, (*b*) by frequent purgatives, (*c*) by too frequent use of enemata. To these may be added the dread of evacuation from pain caused by hard stools. The latter is frequently operative in children. Instead of aiding the evacuation of the bowels, the child resists it with all its might. This resistance to the passage of fæces, partly voluntary and partly reflex, is caused by the pain of extrusion through the sphincter of a hard rough mass, or the existence of a fissure or sore of the anus. When once constipation has occurred this is an important cause of its continuance, to be overcome only by inducing absolute liquidity of stools for a time.

Now the symptoms produced by retention of fæcal waste in the intestine vary remarkably. In some cases, especially in very young milk-fed children (and the fresher and better the cow's milk the more constipating is it, *i. e.*, non-fermenting, not acid), there may be absolutely no derangement of general health. The child eats well, sleeps, is hearty and robust—the picture of health. There appears to be no

fæcal poisoning by reabsorption of foul matter from the intestine. The chief difficulty is the pain caused by the passage of the hardened dry fæces. This causes the child to resist all attempts to go to stool. It screams and cries, and dreads the action, and thus, refusing to assist by its own efforts, the bowels remain closed for days, perhaps, until a good dose of castor oil or other domestic medicine compels evacuation. In addition to this there may be restlessness and night terrors; but the tongue is usually clean, and digestion and nutrition good.

Strong purgations enervate and wear out the tone of the bowel. Continued enemata impair tone and do harm by dilatation. Intermittent treatment aggravates the evil. First, be sure that there is no malformation, intussusception, no painful sore about the anus. Use saline laxatives, as they increase the flow of intestinal fluids. Further aids are strychnia or nux vomica, iron and belladonna.

In the case of children under two, simple carbonate of magnesia (gr. v. to xx.) in milk is sufficient. In older children the sulphates of magnesia and soda, with the above-mentioned tonics and daily massage (abdominal?), are useful. In older children still a pill of aloes or euonymin, with sulphate of iron and nux vomica, may be given as an alternative to the course of salts and strychnia. In mild cases, perhaps, or if the liver is not acting, a dose of calomel, gray powder, and soda or senna may be given. Regimen is an important element in the treatment if the child should have chronic constipation: abundant water, pure, not hard; “salutaris” water is excellent. In little children add a good infants' food to milk; fruits; fruit jellies; treacle; cooked green vegetables of the softer and more delicate kinds. Some variety in food is useful; a good mixture is better than a monotonous diet. It is, I think, extremely doubtful if coarse food is useful in the long run. It causes atony and weariness of muscle eventually by over-stimulation. And you must insist on regular evacuations. Take care that the stools are not dry and hard, or the child will resist action and increase constipation. Other useful adjuncts are: abundance of fresh air, which aids in improving nutrition; and exercise, which mechanically aids the passage of the contents of the intestine down the tube, and improves general

health and muscular tone.—*Lancet*, Dec. 4, 1886.

Holt (L. E.) on the Antiseptic Treatment of Summer Diarrhœa.—Summer diarrhœa is not to be regarded as a disease depending upon a single morbid agent. The remote causes are many—heat, improper and artificial feeding, bad hygiene, etc. The immediate cause is the putrefactive changes which take place in the stomach and bowels in food not digested, which changes often are begun outside the body. These products may act as systemic poisons, or the particles may cause local irritation and inflammation of the intestine. The routine use of opium and astringents is not only useless, but, especially at the outset, may do positive harm; since, by checking peristalsis, opium stops elimination and increases decomposition. Evacuants are to be considered an essential part of the antiseptic treatment. The salts of salicylic acid and naphthalin are the antiseptics which, thus far, seem to be best adapted to the treatment of diarrhœal diseases.—*N. Y. Med. Record*, Jan. 15, 1887.

Atkinson (J. E.) on Rubella (Rötheln).—Rötheln is a specific, contagious, eruptive disorder. While it possesses pretty well-defined characteristics, which, taken together, justify a reasonable degree of certainty in its diagnosis, it has no symptom that may not be and is not often assumed by measles.

A sporadic case, occurring in one who has never had measles and who affords no history of exposure to rötheln, may be diagnosticated with a fair degree of confidence, but not with absolute certainty.

The unqualified diagnosis of rötheln should only be made during an epidemic in which all persons exposed, irrespective of former attacks of measles, are liable to be affected and in whom the symptoms follow a pretty uniform type. In the absence of a pronounced epidemic influence, a series of cases occurring in a household, a school, or an asylum, showing typical symptoms, may be diagnosticated as rötheln with a fair degree of confidence.

In sporadic cases, where neither measles nor rötheln has been experienced, a diagnosis of probable measles or rötheln must be made, accordingly as the symptoms and course resemble the type of one or the other affection.—*Am. Jour. Med. Sci.*, Jan., 1887.

Cole (T.) on a Case of Pernicious Anæmia.—W. B., a cabman, æt. thirty-five, was admitted into the Royal United Hospital, Bath, on June 21, 1886.

He had always lived in England. He had acute rheumatism seven years ago. His health had failed him since January—dyspnœa, nocturnal cough, and anorexia being the prominent symptoms. He was extremely pale, and had a troublesome hacking cough, with very short breath on exertion. There was dulness in the right apex, with defective respiratory murmur and crepitation. There was a double cardiac bruit audible at base and apex, and loudest over the sternum. The liver and spleen were much enlarged. The feet and legs were œdematous. The urine contained no albumen, and its density was normal. His pulse was 96. The temperature was invariably pyrexial in the evening for a considerable period, but gradually became normal. There were numerous variously shaped retinal hemorrhages, mostly striate, and radiating from the optic discs. The red blood-cells averaged about 940,000 per cubic mm. of blood, and the white about 7,500. He expectorated some blood-stained sputum. He was placed upon tartrate of iron, cream of tartar, and digitalis. Under this treatment the œdema subsided, and the general health improved. But the liver and spleen increased in size, and the pallor was extreme. He also had some epistaxis. On July 5th there was a trace of albumen in the urine. On June 28th he was put upon hydrochloric acid, sulphate of iron grs. ii., and liq. arsen. hydrochlor. ℥ iii. ter die. The quantity of arsenic was gradually increased till, on August 2d, a dose of ℥ xii. t. d. was attained. On July 19th the spleen had subsided, and the liver was smaller. On the 26th the red blood-cells had increased to 1,780,000 per cubic mm. On August 3d the weight was 10 st. 2 lbs., the cough had gone, the lung trouble seemed obsolete, and the œdema had almost disappeared. Once only was there a trace of albumen. On August 7th he was discharged, fairly well. He lately presented himself to the hospital in good health, all the morbid symptoms having ceased.—*Bristol Med.-Chir. Jour.*, Dec., 1886.

Henry (F. P.) on Pernicious Anæmia; Extreme Reduction of the Number, with Alterations of the Size and Shape, of the Red Corpuscles;

Recovery.—On October 5, 1885, at the request of Dr. Morris J. Lewis, I examined the blood of a patient under his charge in the female medical ward of the Episcopal Hospital, and sent him the following report :

"Number of red corpuscles per cubic mm., 560,000. Percentage of corpuscles, as compared with the standard of health (5,000,000), 11.2 per cent. Hæmoglobin, 11 per cent. No white seen in the specimen examined. The corpuscles vary greatly in size and shape, many of them being much larger than normal. An undoubted case of pernicious anæmia."

On October 27th I examined the blood again, with the following result : Number of red corpuscles per c. mm., 840,000 ; white not increased ; hæmic unit, 17 ; hæmoglobin, 12 per cent. The hæmoglobin had not increased in proportion to the increase of the corpuscles since the last examination.

On January 26, 1886, the patient was kindly sent to me by Dr. Henry M. Fisher, to whose care she had been transferred by Dr. Lewis, in the regular rotation of hospital service, shortly after my second examination. In a note which she brought with her, Dr. Fisher stated that he had quite recently examined the blood and found 3,431,250 red corpuscles per cubic millimetre.

The result of my examination was as follows : Number of red corpuscles, 3,670,000 ; hæmic unit, 73.5 ; color (hæmoglobin), 38 per cent. ; very few corpuscles above normal size ; most of them smaller than normal ; white very scanty ; a few microcytes.

The patient, æt. thirty-five years, English, domestic, married, sterile, was admitted September 18, 1885. The catamenia began at twelve, and were perfectly regular until June, 1885, when they ceased, and have not since returned. Her father died at the age of eighty-one ; her mother of phthisis at fifty-five ; one brother died of pneumonia at thirty ; two sisters are still living. She was married at nineteen, and has never been pregnant. Has been in the country eleven years, and every summer has suffered from general debility and palpitation of the heart. Dates her present illness from April, 1884, and attributes it to the excitement and over-exertion attendant upon a trip with a sick friend to Harrisburg. Her first symptoms were

gradual loss of strength, with dyspnœa and palpitation on going up stairs ; and sick stomach, with vomiting of watery fluid on rising in the morning. At present—time of admission—she complains of nothing but extreme weakness. Her hair has become quite gray during the last year, and her skin is of an icteric hue, while the conjunctiva is pearly-white, and the nails are whiter than the surrounding integument. Her bowels are moved twice a day, and the stools are natural in consistency and color. The tongue is pale red, without fur. The liver and spleen are of normal size, and no enlarged lymphatic glands can be found. There is no cough. The apex beat of heart is diffuse and slightly tremulous. It is felt in the sixth interspace, but is strongest in the fifth interspace, an inch and a half inside of the nipple. There is a systolic murmur over the anterior surface, loudest over the pulmonary valves. There is a venous hum in the neck.

On admission, there was slight general œdema. The urine was free from casts, but contained pus corpuscles—three or four in every field—and a slight amount of albumen. The general intelligence is very good. Sleep is very poor.

The eyes were examined by Dr. B. Alexander Randall, one of the ophthalmic surgeons to the hospital, who made the following report : "Vessels pale ; veins tortuous, particularly to the temporal side of left eye. No hemorrhagic spots, either new or old."

The treatment adopted was a Blaud's pill and Fowler's solution, gtt. v., thrice daily. This had to be stopped almost immediately on account of vomiting.

On November 4th liquor ferri dialysati, gtt. v. ter in die, was prescribed. The dose was soon increased to twenty drops, thrice daily, and this treatment was continued until the patient's discharge from the hospital on Jan. 23d.—*Medical News*, July 3, 1886.

M'Caw (J.) on the Treatment of Hæmophilia.—Protect from all injuries and avoid particularly the extraction of a tooth. Constipation is very injurious. Diet should consist more of white-meat and fish than of the stronger varieties, with a fair supply of fresh vegetables. In case of premonitory symptoms, enjoin perfect rest, give a mercurial purge, followed by a saline. Regular exercise in the open air should be enforced, but boisterous games, such as football, cricket, etc., had better be

avoided. As regards medicinal treatment, ergot, ergotine hypodermically, and hazeline, have all been highly spoken of and used with apparent benefit in certain cases. Chlorate of potassium and iron may be tried, and for external forms the use of puff-ball should not be overlooked. Flannel should be worn next the skin, together with sufficiently warm clothes, in order that the cutaneous circulation may be well maintained. — *Dublin Four. Med. Sci.*, June, 1886.

Staples (A.) on Suicide by Blows against the Head.—A study of twenty-two cases shows that death often does not result from the immediate effect of the injuries; more often the patient either gets well of them, dies from the resulting inflammation, or tries some other method of suicide. Another lesson to be drawn from these cases is, that even heavy blows against the head do not necessarily produce concussion of the brain.

In a given case, the diagnosis between murder and suicide may be of great importance, and attention to the following points will be of use:

1. The situation of the wounds must be one readily accessible to the hand. The majority of these injuries, as the cases given above attest, are situated on the frontal and parietal bones, more rarely on the temples, very rarely indeed upon the occipital bone.

2. Usually more than one wound, frequently many, are found. It is easily comprehensible that the first blows are made somewhat cautiously, and being comparatively unimportant, do not render the suicide incapable of completing the act.

3. The injuries are, as a rule, huddled together in a comparatively small space, and take a parallel course. This is easily explained by the quick motion that has been taken by the hand. This disposition of the wounds, almost characteristic, is one of the most constant and weighty signs to which our attention can be directed.

4. Heavy strong instruments are regularly used. If they are blunt, fewer wounds are to be looked for, as unconsciousness would be the more quickly induced.

5. In many of these cases, other injuries made with suicidal intent, or traces of them, can be found in other portions of the body.

6. Signs of resistance or non-resistance should in every doubtful case be looked for. Regularity of the wounds, and a

grouping together of them, are not compatible with resistance.

7. The history of the patient, as concerns the mental state, is always of importance. Most of these suicides had shown aberrations of intellect, perhaps of a transitory character, and hereditary taint came often into play. Delirium and cephalalgia were also the causes in one case each.—*Four. Am. Med. Ass'n*, Jan. 1, 1887.

Skeer (J. D.), a Pathognomonic Symptom in the Diagnosis of Tubercular Meningitis.—A small circle forms in the iris, near to and completely surrounding the pupillary margin. When it begins to appear, it is very indistinct and resembles a wreath of thin white clouds, the edge of which extends at first to the free border of the iris. In from twelve to thirty-six hours the whole margin of the iris will be involved, having become of a whitish or yellowish-brown color, and appearing irregular, thickened, and somewhat granular. These changes, which commence in both eyes simultaneously, are more apparent in irides of a brown color. In this connection we should remember that some children, especially those born of scrofulous or tuberculous parents, have a light-colored circle on the free border of the iris, composed of cloudy and white fibres which radiate from the centre toward the circumference. This cloud-like appearance is in some cases very evanescent, hence the necessity of examining the iris at every visit. They may appear in the evening, and by the following morning have given place to the yellow-brown rings caused by the subsequent changes in the tissues. These latter rings are permanent and grow narrower and larger with the progressive dilatation of the pupils as the disease advances.

In cases where tubercle bears an ætiological relation to the meningeal trouble, the circles appear early, before or during the decline of the fever which characterizes the first stage of the disease. In cases where the original simple inflammation has, by its nutritive changes, called into activity a latent tubercular tendency, they appear in the second stage of the disease. In no instance have I observed them in a simple acute case.—*Chicago Med. Four. and Ex.*, Jan., 1887.

Wolfenden (R. N.) on Athetosis Occurring after Diphtheria.—S. S., a young girl, eighteen years of age, had a se-

were attack of diphtheria during the month of November, 1884, for which she was treated as an in-patient at a London hospital. She was discharged convalescent on December 26th. For several days afterwards she experienced burning pains in her right arm and leg. Subsequently she felt that the leg had less power, and used, as she described it, "to give way under her." This weakness of the limb at no time passed into paralysis. She frequently complained of "numbness" in the fingers and toes of the right side, and a feeling of "pins and needles." She was brought to me by her mother on February 3 1885, when I made the following notes:

Patient is an anæmic and unintelligent-looking girl. The mother states that she is obstinate and difficult to control. She has never had chorea or rheumatic fever. The mother states that after recovery from the throat affection, the right foot, and the fingers of the right side were always "on the shake." She frequently complains of an ill-defined pain over the shoulder on lifting any thing with the right arm, also of numbness and "pins and needles" in the toes and fingers of the right side. There is no anomaly of sensation in either arm or leg. The tongue is furred; pulse, eighty-four; headache in the temples; sleeps badly; very anæmic; bowels regular; catamenia regular.

The movements of the fingers and toes of the right side consist of alternate slow flexions and extensions, very constant, with abduction of the fingers and thumb. Occasionally there is an intermittent spasm of the arm, which is thrown outwards, and renders it unsafe to allow her to carry any thing. There are some oscillations of the wrist. The movements are in no way choreic, but resemble in all particulars those falling under the description of "athetosis." The leg is dragged on walking, and particularly if the girl is tired or exhausted.

The girl's mother is a thin sallow woman, subject to periodical violent migrains, and the father is a man of violent temper, who has suffered from sunstroke while in India.

The girl was placed on a course of perchloride of iron and full diet, and in less than a month every trace of paresis and athetosis had disappeared. The interest of the case lies in the fact of athetosis occurring during the convalescent stage of diphtheria along with the slight paresis,

which latter is of course common. I believe the like has not before been recorded. —*Practitioner*, Dec., 1886.

DISEASES OF THE NOSE AND THROAT.

Selections by C. H. KNIGHT, M.D.

Examination of the Nasal Cavities from the Front.—In a valuable paper, by Mr. E. Cresswell Baber, are found several instructive diagrams, similar to those occurring in his volume on "Diseases of the Nose," illustrating the anterior rhinoscopic view. Attention is directed to the occasional difficulty of distinguishing an enlarged tubercle of the septum from a condition of deviation. It is suggested that the tubercle guards the olfactory slit, just as the inferior turbinated body does the respiratory region. Like the latter, it may undergo temporary swelling to a slight degree, or at least it may be reduced by the action of cocaine. Touching this body, even in apparently normal condition, with a probe, gives rise to sneezing, a fact which still further supports the theory of its protective function. With a strong light through and just above the inferior meatus, the movements of the soft palate can very commonly be seen during deglutition and phonation, and, the palate being at rest, the posterior wall of the naso-pharynx is visible. The arches of the choana are also to be seen. During swelling of the anterior erectile body, these parts are, of course, not in view. In the author's experience, interference is much more commonly met with from this cause than from deformity of the septum, or of the inferior turbinated bone. The condition of simple swelling may be distinguished from true hypertrophy of the turbinated body by means of cocaine, and by the use of the nasal probe. The former rapidly contracts under the action of the drug, while the effect upon the latter is slight. The sensation produced by touching the swollen inferior turbinated body with a probe, is that of a soft cushion, which can be deeply indented by pressure, but rapidly regains its original globular shape. Besides giving information about the shape, attachments, and consistence of growths, the nasal probe is indispensable for ascertaining the reflex irritability of different points. As a rule, no reflex phenomena follow touching the

anterior extremity of the inferior turbinated body; exceptionally cough is produced.—*Brit. Med. Jour.*, Dec. 11, 1886.

Deformities of the Nasal Septum.

—Dr. F. H. Bosworth read a paper at the N. Y. Academy of Medicine, based upon a series of cases treated with the nasal saw. Deformity of the septum is regarded as the most frequent cause of catarrhal disease of the upper air-passages. The different varieties of deformity were described, and the opinion was expressed that deflections and deformities of the nasal septum always result from traumatism. The various operations for correction of deflection were referred to, and the nasal saw preferred by the author was exhibited. The blade is as thin as possible consistent with strength, an eighth of an inch in width, five inches long, with a cutting edge of three inches, thirty teeth to the inch, each tooth an exact equilateral triangle, with no cross-cut or set to the teeth, the handle being three inches long and attached at an angle of forty-five degrees. The instrument should be held straight, and moved as rapidly as possible. Cocaine prevents all pain. Immediately after the operation, hemorrhage is profuse, but it soon ceases, and plugging is very rarely necessary. Delayed healing is apt to occur only in case the sawing is not done in a straight line.—*N. Y. Med. Jour.*, Jan. 15, 1887.

Some Rare Cases of Perforation of the Nasal Septum.—*Rev. mensuelle de Laryngologie*, Nov., 1886.—Schmiegelow relates the particulars of three cases:

1. In a man, aged sixty-four, in whom almost the whole of the cartilaginous part of the nasal septum was absent, and which S. thinks is a congenital deformity for the following reasons:

- (a) It had been present from infancy.
- (b) There had never been symptoms of nasal disease.
- (c) There was no history of tuberculosis or congenital syphilis, nor of injury.
- (d) The mucous membrane evenly surrounded the hole with no trace of cicatrices.

2. In a lady, aged thirty-three, who had suffered since infancy from epistaxis, especially from the left nostril, which was often obstructed by crusts. Since puberty the bleeding and other symptoms have lessened, and, she would not have known that there was any thing the matter with the nose, had not her brother, who is a

doctor, accidentally found that she had a perforation of the cartilaginous portion of the septum. The margins of the hole are in parts smooth, but in part also ulcerated.

S. considers this perforation due to a traumatic perichondritis, caused by the continual irritation set up by "picking the nose," in order to free it from the crusts that had formed as a result of the epistaxis.

She was cured by the application of chromic acid.

3. In a lady, aged forty-seven. She complained of much purulent discharge from the nostrils, also fetid crusts.

The right nostril was very large, and the left very small, owing to deviation of the septum, and the latter nostril was almost filled with thick fetid purulent discharge and crusts, and on cleansing it the mucous membrane of the osseous septum was seen to be granular and rough, over an area as large as a sixpenny piece. Bare bone could be felt with the probe. Cauterizing with chromic acid, insufflations with powdered nitrate of silver, scrupulous cleanliness, and scraping with the sharp spoon once, cured the condition. There was no history of syphilis, and the use of pot. iod., before local measures were adopted, was of no value.—*Bristol Med.-Chir. Jour.*, Dec. 1886.

Plugging the Posterior Nares.

Dr. James Brydon suggests the following method: Take a piece of twine of sufficient length, and fasten to the end of it a pledget of lint or rag, the size of a large pea, or a small globular button with a neck does very well. Then form a ring about a quarter of an inch in diameter, on the small end of a silver probe or piece of wire, and bend it down. Run the twine through the ring till the pledget or button is close against it. Then pass the wire or probe along the floor of the nose; tell the patient to hawk, and spit out, and at once the pledget with the twine attached is ejected.—*British Med. Jour.*, Jan. 8, 1886.

The Treatment of Epistaxis.

German Med. Soc., Strasburg, Sept., 9, 1886.—Kiesselbach agrees with Michel and Voltolini that epistaxis is due, in a great many cases, to dilatation of the capillaries of the mucous membrane of the antero-inferior part of the cartilaginous septum, whereby a cavernous tissue, like that covering the turbinated bones, is produced. Destruction of this membrane prevents

further bleeding. — *Bristol Med. Chir. Four.*, Dec., 1886.

Tubercular Ulceration of the Fauces.—At a meeting of the Medical Society of London, Dr. J. Abercrombie and Dr. Gay read a conjoint paper on three cases of acute tubercular ulceration of the fauces. The authors related three cases of acute tuberculosis in children in which ulceration of the fauces occurred within a few days or weeks of death. In one of these cases the ulceration was shown by microscopical examination to be tubercular. In the other two there was no reason to doubt that it was of the same nature. Pain in the throat and dysphagia were the only premonitory symptoms of this affection, soon followed by the development of whitish punctiform spots, about the size of a pin's head, on the soft palate, uvula or tonsils. In the course of a very few days these spots enlarged and coalesced, subsequently breaking down and leaving variously shaped irregular superficial ulcers. The ulceration may spread until the whole of the fauces is involved. The death of the patient usually occurs before the ulceration is far advanced. Generally the fauces are more or less constantly covered with a viscid secretion, which greatly adds to the difficulty of diagnosis. The usual symptoms of acute tuberculosis will be present, especially the fever and emaciation, but the other signs of the disease are often masked. There is usually, but not always, considerable enlargement of the glands of the neck, and these may suppurate. The authors regard this form of angina as only a part of general tuberculosis, in which respect it differs entirely from the chronic tubercular ulceration of the fauces, which is either primary in the pharynx or spreads there from the larynx. The disease always proves fatal, though the patients do not usually or necessarily die from the throat affection.

Dr. Percy Kidd could not agree that there was any actual distinction between acute and chronic forms. The disease might spring from the larynx or was primary, but it should not be lost sight of that the expectoration from the lung might be the source of it. Of five hundred necropsies, he had met with six or eight cases of tubercular disease of the pharynx. Sometimes the disease began as minute whitish specks, followed by ulceration, and this only one month before a fatal termination. Herpetic vesicles on the pharynx might

cause some difficulty in diagnosis for a time. — *London Lancet*, Nov. 13, 1886.

The Galvano-Cautery in the Treatment of Papilloma of the Larynx.—A thesis with the above title was presented to the Am. Laryngological Ass'n at its recent meeting, by Dr. A. W. MacCoy, as a candidate for membership. The case which is reported is of rather unusual interest. It occurred in a man 28 years of age, whose first symptom of laryngeal trouble, observed two years previous, was inability to sing low notes. In the course of six months his speaking voice became hoarse and weak, and a short cough developed. Finally his voice became reduced to a whisper, and attacks of dyspnoea became frequent. The following laryngoscopic appearances were observed: The left vocal band and the arytenoid were seen to be immovable upon phonation, remaining abducted; paralysis of the lateral crico-arytenoid and arytenoid muscles; the right vocal band was only partly visible, being obstructed in its middle and anterior portion by an overlapping tumor of irregular outline, and of a pale red color. It was quite bulky, and appeared to spring from beneath the vocal bands. On phonation, the growth in part appeared between the vocal bands, and prevented free movement of the right side. Mackenzie's forceps were used to remove portions of the growth, but it reproduced itself with such rapidity that this method of treatment was abandoned. After trying various other forceps, guillotine, and snares, the larynx was anæsthetized by cocaine, and a pointed electrode, covered with rubber, was introduced into the middle of the papillomatous mass, and after a few seconds withdrawn. Considerable shrinkage took place and no unpleasant consequences followed. Several operations (number not mentioned) were required to completely destroy the neoplasm. The voice was at last fully restored, but not quite pure. In phonation, the paralysis of the left vocal band, which persisted, was fairly compensated by over-action of the right. Less than a 20 per cent. solution of cocaine has not succeeded in producing complete anæsthesia of the larynx. The condition may be maintained for at least one hour by re-applying the solution every ten or twenty minutes. The Seiler-Flemming battery has given the author the most satisfaction. A perfectly white heat and a finely-pointed electrode with a light handle, having the

binding posts at its middle instead of at the end, ensure most thorough destruction of the new growth with least danger to contiguous tissues.—*Phila. Med. News*, Jan. 1, 1887.

Lupus of the Larynx.—At a meeting of the Medical Society of London Dr. Orwin showed a case of lupus of the larynx in a woman, associated with the same disease of face and nose.

Dr. Colcott Fox showed a case of lupus of the larynx associated with lupus of the face, palate, and scalp, in a boy aged seven years. Kaposi said that autochthonous affection of the larynx with lupus was unknown. Dr. Felix Semon said that papillary excrescences and ulceration of the epiglottis were to be seen. He did not think lupus of the larynx so rare. Chiari had collected forty cases. In perhaps 5 to 8 per cent. of cases of lupus the larynx had been involved.—*London Lancet*, Dec. 25, 1886.

The Treatment of Tubercular Ulceration of the Larynx by Lactic Acid.—*Revue mensuelle de Laryngologie*, July, 1886.—Krause first used lactic acid in this formidable disease, and considers that he has had very good results from it. Jellinek confirms Krause's observations. Hering has carefully studied the matter, and of twenty cases has had—four, complete cure; two, almost complete cure; four, considerable amelioration; six, functional amelioration. The cases in which most good can be obtained are those in which the ulcers are circumscribed, and are on the vocal cords or epiglottis, the pulmonary affection not being far advanced. On the other hand, crater-like ulcers of the ventricular bands, or of the interarytenoid mucous membrane usually have to be scraped, deeply incised, or cauterized by chromic acid before the lactic acid is applied. Hectic fever, emaciation, much dysphagia due to ulceration, and advanced pulmonary affection are contra-indications to its use.

Method of application: First brush a 10 per cent. solution of cocaine over the affected parts, then swab on with piece of cotton-wool a 20 to 30 per cent. solution of lactic acid. After a few days the solution of the latter may be of 80 per cent. strength, or even as concentrated as possible; the cocaine can be dispensed with as the parts

become more tolerant. The operation must be repeated every day until an eschar forms. In addition to this local treatment, attention to the general health is of great importance.

Fraenkel and Schrötter approve of this method of treatment. Schnitzler still believes in iodoform insufflated into the ulcers.

Rosenberg has got good results from a 20 per cent solution of menthol in olive oil, locally applied.—*Bristol Med.-Chir. Four.*, Dec., 1886.

SOME RECENT CASES OF EXCISION OF THE LARYNX.

A Case of Excision of the Larynx for Epithelioma, with Death from Exhaustion on the Eighth Day.—Mr. H. Morris described the case of a man, aged 59, who for over three years had suffered from laryngeal obstruction. Tracheotomy gave no relief, so the whole larynx was excised, with great relief to the patient. He did well for a few days, but sank on the eighth day. The author considered that there were only two conditions which indicated and justified excision of the whole larynx: (1) Where the disease is confined to the larynx; (2) where, after tracheotomy, the sufferings of the patient are persistent, and suffocative cough and dyspnoea cannot be relieved by other means.

Partial Extirpation of the Larynx for Epithelioma of the Left Ventricle of Morgagni; Recovery.—Dr. Felix Simon described the case of a bar-rister, aged 52, whose only complaint was loss of voice, developed out of slight hoarseness. With the laryngoscope the left vocal cord appeared embedded in a warty tumor, about the size of a small bean. Microscopic examination of a small portion showed it to be a carnifying epithelioma. Extirpation of the left half of the larynx, with the exception of the cricoid cartilage, was successfully performed by Eugen Hahn. The patient made a good recovery, which was retarded by extensive bronchial catarrh, due apparently to escape of fluid into the air passages, an occurrence which should therefore be carefully guarded against. Five months after the operation the patient is quite well, swallows with ease, is free from any trace of recurrence, and speaks so well that he wishes to return to the bar.

¹ See MEDICAL ANALECTIC, 1886, p. 552.

A Case of Epithelioma of the Vocal Cord, for which Partial Excision of the Larynx was Performed.

—Mr. Butlin described the case of a gentleman, aged 50, who had hoarseness for two years. A warty growth was found in the left vocal cord. Portions of the growth were removed with forceps, but it recurred and extended. The left half of the larynx was removed, with the true and false cords on the right side, as the disease had extended to them. Hahn's tracheotomy tube was used during the operation, and was kept in for two days.

Mr. Lennox Browne asked Mr. Morris at what position in the trachea the tracheotomy had been performed, because it was very important that it should be performed as low as possible. He thought there was a good deal in the statement as to the exhaustion brought about by the tracheotomy performed previous to the operation. He was of opinion that it would be better to do the tracheotomy on the date of the operation, and not some time before, seeing that the only result was the production of grave and unnecessary discomfort to the patient. He quite endorsed the wisdom of making a careful microscopical examination of fragments of growths. He thought, however, that repeated interference with laryngeal growths not unfrequently changed the nature of the growth, which became malignant. He did not wish to say that this was so in Dr. Semon's case, but in Mr. Butlin's case. He had seen cases which appeared benign in the first instance subsequently become malignant. He did not think Dr. Semon need have the slightest hesitation as to the justifiableness of the operation. The cases laid before them might well disarm opposition to the operation as such. At the same time it should be remembered that intra-laryngeal cancer, entirely confined to the larynx, was exceedingly rare. Lastly, he would remark that neither of the two patients who had apparently recovered were really out of the wood, although one was entitled to hope for the best.

Mr. T. Pickering Pick said he had once performed the operation of total extirpation of the larynx, and his feelings were certainly that he hoped he would never have to do another. After the operation had been performed, he was horrified at his own handiwork, and he was bound to confess to a feeling of relief when the patient died. The enormous chasm left by the removal

of the larynx was even then present to his sight. He agreed with Dr. Semon's remarks as to the necessity for early diagnosis and careful selection of cases. In reference to Mr. Butlin's case, he mentioned that he had performed a similar operation, carefully scraping the cartilages, but the disease returned, and the patient died within four months. Another little practical point was as to the manner of feeding the patients after operation, for which purpose he would advocate the use of a soft rubber tube, passed through the nostrils, and left *in situ*.

Mr. Morris, in answering Mr. Lennox Browne's question as to the site of the tracheotomy, said that the first and second rings of the trachea had been divided. Doubtless, if the tracheotomy were done with a view of assisting the operation, the high operation was of advantage. As to the method of administering food, he had employed the very soft tubes known as Durham's tubes, and would have liked to have left them *in situ*, but the inconvenience to the patient was so great that the other plan had to be resorted to. The plan of feeding *per rectum* had to be abandoned for the same reason. The operation was undertaken at the urgent instances of the patient, who desired relief at any price.

Dr. Semon said he hoped it would not be inferred from his paper that he advocated a careful selection of cases with a view simply to the production of good statistics. Yet, if cases of any sort were operated on, the mortality tables of the operated would be so high that no surgeon or physician would recommend it to be done in any case.

Mr. Butlin said that he had regarded the case as probably malignant from the first. Mr. Morris' statements required a serious answer, for they seemed to be in defence of a system of surgery which ought on no account to be upheld. Hahn had reported one case, and one case only, where the patient was alive and well four years after the operation, and there were only six cases in which the patient was alive and well more than a year after the operation. His mortality was 35 out of 65 cases from the effects of the operation alone. If a well-to-do patient were to ask: (1) Was the operation dangerous? the answer would be: Yes, very dangerous. (2) Was a cure certain? the answer would be that nothing was less certain, since in a vast majority of

cases the disease recurred, and that promptly. (3) Would relief be obtained? all one could say was that it was very doubtful, and even improbable.

At a meeting of the section on Laryngology and Rhinology of the N. Y. Academy of Medicine, held January 25, 1887, Drs. Gerster and Gleitsman exhibited a patient upon whom partial extirpation of the larynx had been performed. — *Provincial Med. Four.*, Jan. 1, 1887, and *Med. Press*, Nov. 17, 1886.

Diphtheria—Its Treatment.—Unusual success is claimed by Mr. James Mercer for the following method of treatment. Marked depression, even unaccompanied by extensive local lesions, is looked upon as indication for the use of sol. of perchloride of iron in drachm doses every two hours. (1) The iron is begun, after the administration of a gentle aperient, and is given in a mixture containing dilute nitric acid, glycerine, and water. (2) As the patches of diphtheritic membrane extend, and the temperature and glandular enlargements increase, a single dose of apomorphia, three to five minims, is given, which results in expulsion of portions of slough and relief of dyspnoea. (3) If the patient can use a gargle, a half drachm of pure hydrochloric acid is added to a drachm of chlorate of potash in a six-ounce bottle, which is filled with water while the nascent chlorine gas is being generated, and an ounce of the solution is used every third hour. (4) Strength is maintained by the frequent use of small quantities of milk and beef-tea and the free administration of alcohol. — *London Lancet*, Oct. 30, 1886.

The Simplest and Most Efficient Treatment of Diphtheria.—In a paper read before the eighth annual congress of the Am. Laryngological Ass'n Dr. W. H. Daly vigorously advocates the use of calomel, and formulates the following rules: (1) Give calomel in its purity; (2) give it in large doses; (3) give it frequently; (4) give it until you have the free and characteristic catharsis; (5) give light, nutritious diet; (6) give little or no other medicine.

The Success of the New Treatment of Diphtheria by the Galvano-Cautery.¹—The following conclusions are reached from a critical study of the experience of Bloebaum, who has for several years been experimenting with the effect of

the galvano-cautery upon mucous membranes:

1. The galvano-cauterization of the diphtheritic membrane produces no pain, or only a minimal one.

2. The thoroughly cauterized part is rendered absolutely sterile, and forbids the development of microbic life.

3. Fever disappears soon after the cauterization.

4. No inflammatory secondary effects set in.

5. Every physician is able to execute the cauterization, even without an assistant.

6. No constitutional medicinal treatment is needed in addition to the cauterization.

7. Though the statistics of diphtheria cases thus treated are of course yet very limited, the thousands of ulcers of the cornea treated and cured in the same manner allow of very favorable prospects regarding the treatment of diphtheria with the galvanic cautery.

In the *Deutsche med. Zeitung*, Jan. 18, 1886, Bloebaum gives detailed histories of several cases thus treated, which are very remarkable. — *Therapeutic Gazette*, March 15, 1886.

A Case of Pseudo-Membranous Laryngitis Treated by Electrolysis.

—Dr. H. E. Waxham narrates a case of membranous croup treated by using an intubation tube threaded with platinum wire, insulated by means of rubber tubing, as a negative electrode, the positive sponge electrode being applied externally to the larynx. The child was eight years of age, had been sick nearly a week, was already semi-comatose and in a most desperate condition. A current from eight cells of a McIntosh galvanic battery was passed five minutes, meanwhile considerable mucus and softened membrane being expelled. Two and a half hours later the operation was repeated with ten cells, the intubation tube during the interval having been withdrawn. Similar results were observed, and the patient's condition was greatly improved. Six hours and a half of comfort ensued. Then dyspnoea recurred and signs of pneumonia appeared. The tube was reintroduced, giving immediate relief, but electrolysis was not again resorted to. In twenty-four hours the patient died without return of dyspnoea. The current seems to have had a decided effect in loosening and detaching the membrane, but secondarily it appears to have increased the swelling.

¹ See MEDICAL ANALECTIC, 1886, p. 155.

With the assistance of Dr. Büfner, Dr. Waxham conducted a series of experiments upon rabbits without reaching definite conclusions. The author is in doubt as to the proper strength of current to be employed, a point which can be determined only by further investigation.—*Four. Am. Med. Ass'n*, Jan. 1, 1887.

DISEASES OF THE EAR AND EYE.

Moure (E. J.) on the Treatment of Obstruction of the Eustachian Canals.—The author draws attention to the treatment of those cases of subacute catarrh of the middle ear, in which the Eustachian tubes become occluded from thickening of the mucous membrane. Every one who has to do with such cases finds often that insufflation, though carefully and conscientiously performed, fails to pass the obstruction. Sometimes a few bubbles of air may pass at irregular times, and after many sésances, and with pain. His method consists in first anæsthetizing by a ten-per-cent. solution of cocaine hydrochlorate. Some minutes later not only was the anæsthesia complete, but the mucous membrane was considerably retracted, permitting the entrance of the catheter with ease, thus avoiding the alarm which often proves too much for some timid patients. At first he limited his painting to the small region along the nasal fossæ. A little later he carried his application to the level of the naso-pharyngeal cavity. He now introduces as far into the Eustachian tubes as possible a few drops of a seven-per-cent. solution of cocaine muriate. The effect of this treatment did not fail to take place at the end of a few minutes; air could penetrate into the drum, and ameliorated the patient's condition notably. He always finds this procedure successful. This is a new and useful application of cocaine, whose services are already considerable. Not only does it produce sufficient anæsthesia and render catheterism absolutely insensible with timid people, but besides, at the first sésance, one makes a useful and agreeable treatment to the patient: useful because one can insufflate emollient vapors or the very weak astringents or balsams; agreeable because at the outset the amelioration obtained encourages patients to continue a treatment

that will be profitable to them. This enlargement of the nasal canal by cocaine has already been made use of by Dr. Bryson Delavan for extracting foreign bodies from the nose. In the same way for rendering obstructed Eustachian canals permeable it will prove to be of incontestable service.—*France Médicale*, November 27, 1886.

A. T. M.

Spear (E. D.) on a Case of Deafness Following a Blow.—A girl of sixteen applied at my clinic at the Carney Hospital for the relief of unilateral deafness and presented this history: Four years before, while returning from school, she was maliciously attacked by boys, who severely snowballed her. A hard, icy mass, thrown with force, struck upon her right ear (over the surface of the temporal bone, opposite the meatus properly).

She immediately felt pain in the ear, which continued until the next morning.

Coincidentally with the receipt of injury, and persistently thereafter, total loss of hearing was also complained of. No other symptoms were at any time present.

Examination of the affected ear at the time of my visit revealed nothing abnormal to the eye. Absolute loss of hearing for both air- and bone-conduction, as shown by ordinary and by Knapp's test, was proven. Simulation not being likely, the stethoscope test was not used.—*Bost. Med. and Surg. Jour.*, Jan. 20, 1887.

Baratoux (J.) on New Procedures for the Closure of Perforations of the Membrana Tympani.—Berthold attempted to close perforations of the membrana tympani by grafts of skin from the arm. These proved too thick and difficult to adapt to the edges of the perforation. He then abandoned this for the lining membrane of eggs, which is known to be vascular and capable of resisting putrefaction for some time. A fresh egg only must be used, and a suitably sized piece applied to the perforation by means of a canula.

Dubousquet substituted for the last-named membrane bits of interdigital skin from the frog's foot.

The author has used the nictitating membrane of the frog's eye for the same purpose with good results. He also has used it to restore mucous membrane in certain forms of rhinitis.—*Le Prog. Méd.*, Jan. 1, 1887.

Cocaine in the Treatment of Gonorrhœal Ophthalmia.—Mr. A. Leahy re-

ports (in the *Indian Med. Gazette*, July, 1886) two cases of gonorrhœal ophthalmia, both of which were greatly benefited by application of cocaine. It is of primary importance to lessen the inflammation rapidly, to relieve the intense congestion of the conjunctival vessels and reduce chemosis, and by so doing prevent ulceration and sloughing of the cornea. Last, but not least, is the relief of the ocular and circumorbital pain, which, by its persistence, greatly depresses the patient and prevents sleep. Mr. Leahy employed a mixture composed of one half grain of sulphate of atropine and four grains of sulphate of cocaine incorporated with 100 grains of vaseline. After three days' treatment the chemosis rapidly became less, the discharge diminished in quantity, the pain completely disappeared, and the cornea, which had been hidden by the chemosis, became visible.—*Med. and Surg. Reporter*, Jan. 1, 1887. A. T. M.

Greenway (H.) on the Use of Ice and Carbolic Acid in the Treatment of Injuries and Inflammation of the Eyes and Eyelids.—Not long ago I was called on to attend a case of chronic catarrhal ophthalmia in a middle-aged woman. In the progress of the disease various structures of the eye had become involved, and the medical treatment—including tincture of iron, occasional doses of pil. hydrarg. and pulv. ipecac. comp., and warm poppy fomentations—was producing but little effect. I then tried the application of ice and carbolic acid, not omitting the iron mixture, and in the course of a few days marked improvement had taken place. The case continued to improve, and was cured within three weeks from the commencement of the altered treatment. I have since treated various inflammatory affections of the eyes in a similar manner with success. They include phlyctenular ophthalmia, keratitis, scleritis, and non-specific iritis. Within the past month I attended a young child for an acutely inflamed cornea, with an elongated ulcer in the centre, the result of measles. The ice and carbolic application, and five minim doses of tincture of iron every four hours, proved a cure in a comparative short period.

The mode of applying the ice and acid solution is to place those ingredients in a small pig's or sheep's bladder, suspended from a band passing across the patient's

forehead, and encircling the head, the bladder lying in front of the affected eye, fresh supplies of ice and acid to be added as often as required. In order to prevent injurious effects by a too prolonged application of extreme cold, the bladder should be removed occasionally, and reapplied when returning warmth is perceptible. The acid solution is made by adding half a fluid ounce of the glycerine of carbolic acid, *B. P.*, to a pint of water. A tablespoonful of this solution will be sufficient to place in the bladder at a time.—*Brit. Med. Jour.*, Sept. 18, 1886. A. T. M.

Johnson (W.) on Four Cases of Cornea-Grafting.—The following four cases of cornea-grafting were done in Jabalpur, E. Indies, during the present year. They were all, though carefully done and attended, unsuccessful. Only cases where the sight of both eyes was practically lost were selected. Then I endeavored to satisfy myself of the healthy condition of the fundus by finding out if there was any perception of light and of shade, especially of sunlight, or the light of a lamp, etc. Having settled this point, I took the tension of the eye; got the history of the case, and so on. Eyes with staphylomatous cicatrices were rejected, as also were those with nystagmus. If the tension was about normal, the perception of light decided, and the history of the case in other respects favorable, I considered it a suitable one for operation. The younger the patient, and the shorter the time that has elapsed since the loss of sight, the more hopeful, *ceteris paribus*, will be the result of the operation. As to the cornea to be transplanted, I selected rabbits', because, being small, they are easily managed. The rabbit's cornea has also nearly the same thickness and nearly the same curvature as the human cornea.

Having anesthetized the front of the patient's eye with cocaine, I trephined a circular piece from about the centre of the opaque cornea, by applying first the bone guide, and then the trephine through the hole of the former. If the bone guide be firmly pressed on the eye, no other instrument of fixation is needed, except, of course, the eyelid-speculum. When the trephine is nearly through, it is found to yield and, perhaps some vitreous escapes. It is now taken away, and the excised portion seized with small forceps, and entirely cut away with the point of a von Graefe's

cataract-knife. This is usually necessary from the iritic adhesions at the back of the cornea. The edge of the wound is now well cleaned with a small knife and forceps, and any bleeding stopped with cold water. Sometimes the hardened remains of the lens or its capsule are found behind the cornea. These should be removed, and the vitreous allowed to present. All being ready, the selected full-grown rabbit is now killed by an assistant. Immediately the rabbit is killed, a portion of the centre of one of its corneæ is excised by the trephine in the same way as the piece from the patient's eye. For this purpose, a cutting edge of slightly larger diameter is fixed to the trephine. The graft is taken up with small forceps, washed in warm water, and immediately put into the patient's eye. The object of making the graft slightly larger than the aperture in the patient's eye is now seen, for with a little care it can be easily put into its place, and being, as it were, a tight fit when the eyelids are carefully closed and padded and bandaged, it will remain where it has been placed without the use of any sutures whatsoever. If it shows any tendency to sink into the eyeball, there is still usually no difficulty, as the reaccumulation of the aqueous and vitreous humors will press it outwards, and it will be kept in place by the pressure from without on the one hand, and the pressure of the eyelids from without on the other.

Another advantage in having the graft slightly larger than the aperture is that, being pressed more firmly against the edge of the latter, it grows to it more quickly, and, of course, its nutrition is also sooner re-established. This is, indeed, a vital point, and the success of the whole operation turns upon maintaining the vitality of the graft, and in restoring its nutrition as soon as possible. After this the patient is kept very quiet for two days, at the end of which he is laid on the table, the bandage removed, and the upper eyelid carefully raised to see if the graft is in the right position, and growing to the surrounding parts. The eye is again closed up for two or three more days after which it is daily opened, cleaned, and examined, and carefully re-bandaged to protect the graft from injury. Very weak solutions of carbolic acid were used for cleansing purposes. After the first three days the patient is allowed to move about.

The four cases all agree in this: the

grafts fixed themselves, and grew to the surrounding tissues, without any difficulty. Then their vitality seemed gradually to decline, as shown by the progressive loss of transparency, and by the absence of feeling when touched, and also by the partial loss of their epithelium. Finally, they became red and opaque, apparently by overgrowth from the outside, and lost their individuality, and seemed to dwindle away. At the end of about three months it would be impossible to say, from the appearance of the eye, that a corneal graft had been made.

The uniformity of the results in all cases, on the Continent and at home, that I find mention of, viz.: advancing opacity and final uselessness for vision of the corneal graft, points clearly to some common cause or causes of failure, whether inherent in the eyes operated on, the grafts themselves, or the methods of operation, that will demand the attention of all future operators in this direction.—*Brit. Med. Jour.*, Dec. 18, 1886.

A. T. M.

Williams (A. D.) on the Use of the Cautery in Ulcers of the Cornea.—

The *modus operandi* is as follows: The eye must be thoroughly cocaineized. When anæsthesia is complete, the lids are separated, the eyeball is held firmly with the fingers, and the actual or the galvano-cautery is quickly applied to the surface of the ulcers. The application must be made lightly and rapidly, since superficial cauterization is all that is required. The whitish or yellowish points of infiltration or deposit on the surface of the ulcer must always be touched; the clean portions of the ulcer on the other hand should be left alone. The merest touch is sufficient, otherwise there is great risk of perforating the cornea. The object of the treatment is not to destroy the already necrotic material on the surface of the ulcer, which could never be made to live again, but to kill the micro-organisms which infect the cornea and cause the ulceration.—*St. Louis Med. and Surg. Jour.*, Aug., 1886.

A. T. M.

Benson (A. H.) on Fibroma of the Cornea.—

Sections were shown of a fibrous tumor, removed by dissection from the anterior surface of the apex of the cornea of a girl aged nineteen, otherwise healthy. It had commenced near the apex of the cornea about three years previously, and had slowly grown in density and extent without

any past or present sign of inflammation in its neighborhood. It was of a dense white color, measured about 4 mm in diameter and 1 mm. in thickness, and was raised above the surface of the surrounding cornea, with sharply defined margin. Its surface was evenly covered by the corneal epithelium. When dissected off, the cornea under it was perfectly transparent and normal-looking. There was no vascularity in or about the tumor, or anywhere in the cornea, nor was there any history of such having been present at any time. The tumor commenced and grew painlessly. Microscopic examination showed it to consist of apparently normal corneal tissue, with cells and corpuscles. It seemed to be a case of true corneal tumor, though Alt, in his "Histologie des Auges," p. 40, states his disbelief in the occurrence of such. This tumor had nothing whatever to do with the limbus conjunctivæ or the episcleral tissue, the usual origin of so-called corneal tumors.—*Dub. Four. Med. Sci.*, Jan., 1887. A. T. M.

Frothingham (Geo. E.) on the Safety of Cocaine as an Anæsthetic in Cataract-Extractions.—The author draws the following conclusions from a personal experience in thirty-nine cases:

Cocaine relieves the operator from the embarrassments during the operation for cataract that arise from vomiting; also from the agitation of his patient which results from excessive bronchial secretion or stertorous breathing. These are often very troublesome when ether or chloroform is used.

The danger to the result which often arises from nausea and vomiting after the extraction, when other anæsthetics are employed, is very surely avoided when cocaine is selected as the anæsthetic agent and is properly used.

The danger arising from the depressing effect of cocaine upon the nutrition of the cornea is no greater than in cases where ether or chloroform is used. The depression of the circulation, which often arises from either of them, may affect very injuriously the corneal nutrition.

The disturbance of the circulation of the interior of the eye, and consequent danger of panophthalmitis from this cause, is probably less in using cocaine for this operation, than in resorting to general anæsthesia.

The danger of sepsis and consequent pan-

ophthalmitis from the use of cocaine may be avoided by using only fresh solutions.—*Four. Am. Med. Ass'n*, Aug. 21, 1886.

Taylor (C. B.) on Resection of the Optic and Ciliary Nerves as a Substitute for Enucleation.—During the last six years I have treated thirty-one patients in this way, and the results have been most gratifying; relief has been complete, motion in all directions is perfect, and, in point of fact, it is difficult in some cases to tell which eye has been done. Herein, it appears to me, is the solution of Mr. Adams Frost's pertinent question: "What shall we do with a lost eye?" Enucleation is mutilating and unsatisfactory, exenteration is dangerous, and, moreover, apt to excite sympathetic ophthalmia, a glass vitreous appears to me likely to aggravate the evils of a foreign body by its constant presence in the orbit, and destruction of the conjunctiva is merely the expression of despair.

We are bound in all honor, and by every law, not to remove or destroy any portion of the organism which can by any possibility be saved, and I think we shall best fulfil this injunction, this first canon in surgery, by adopting in suitable cases an operation which, as Professor Schweigger has remarked, "is quite as effectual as enucleation, and has this great advantage, that it does not sacrifice the eyeball, or render an artificial eye necessary."—*Brit. Med. Jour.*, Sept. 18, 1886.

Rolland (E.) on Diffuse Hemorrhage into the Vitreous; Ophthalmotomy; Recovery.—Similar cases treated expectantly do not do well. The operation advocated by Rolland is not difficult, and requires no special instrument. With a Graefe's knife, after puncturing the membranes, he cuts forward to within 6 mm. of the ciliary circle, between the superior and external rectus. The patient referred to could count fingers the morning after the operation. Rolland explains the speedy relief by the lowering of the intra-ocular tension. In case the ocular tension is extreme, oozing often continues after the withdrawal of the knife.

The prognosis without operation in these cases is so poor that any operation holding out hope is justifiable.—*L'Union Méd.*, Jan. 4, 1887.

Panas on Congenital Serous Cysts of the Orbit.—The author thinks that congenital orbital cysts are caused by

the shutting off of a diverticulum from the mucous membrane, as they are always seated at the inner side of the orbit, next the mucous membrane of the nasal fossæ and maxillary sinuses.—*La France Méd.*, Dec. 16, 1886.

Dufaud (G.) on Atrophy of the Optic Nerve Following Erysipelas of the Face.—The optic nerve is often seen to atrophy after facial erysipelas. Implication of other orbital contents, particularly the third pair, is frequent. The lesion is bilateral or unilateral, and in the latter case the corresponding side of the face is alone inflamed or more severely involved by the erysipelas than the opposite side. Progressive and partial, not sudden or complete, impairment of vision is the rule in these cases.

The author hazards no theory as to the pathology of these cases.—*L'Union Méd.*, Dec. 23, 1886.

SURGERY.

Thiriar (J.) on Pneumotomy for a Large Pulmonary Cavity; Recovery.

—A young man of twenty-two entered the hospital for a left pleurisy with effusion. On June 22d this effusion was determined by puncture to be purulent. June 27th the patient coughed up a great quantity of pus, and there were undoubted signs of a cavity in the postero-lateral region of the chest, which evidently was an interlobar abscess connecting with a bronchus.

The patient failed rapidly, and July 5th M. Thiriar performed the operation for empyema in the eighth intercostal space. The patient continued to expectorate pus, and Aug. 27th M. Thiriar performed the radical operation of pneumotomy. He raised up an immense flap of skin, resected from 5 to 9.5 centimetres of four ribs, saving the periosteum. Then with the actual cautery he slowly penetrated the tissue of the lung, which was apparently healthy and cupped, the parietal and visceral pleura being adherent, soon reaching the cavity, which communicated with the bronchi. He gently washed out the cavity with sublimate solution, introduced two large drainage tubes, and replaced the cutaneous flap by sutures.

At different times subsequently the drainage tubes became clogged, the expectoration increased, and the temperature

went up. In October radical improvement commenced, and by the end of the month the patient was practically well, there being no cough nor expectoration.—*Le Scalpel*, Jan. 1, 1887.

Désir de Fortunet (H.) on Rupture of the Diaphragm and Lung without Fracture of the Ribs.—A man of thirty-five was injured in the hepatic region by being caught between two freight cars. When first seen by the surgeon he was semi-comatose, extremely pale, and covered with a cold sweat. The breathing was irregular and intermittent, the pulse small and rapid. There were no external wounds, no broken ribs, and there had been no hæmoptysis. On admission to the hospital the patient had all the signs of internal hemorrhage.

Among other lesions on autopsy, there was found an effusion of blood into the muscles of the right iliac fossa, while there was a large quantity of blood in the abdomen and pelvis. To the left of the median line there was a large rent in the diaphragm, which admitted a partial hernial protrusion of the stomach into the pleural cavity. The lung on this side was adherent at its base and the seat of three large tears. The entire surface of the lung was covered by firm, adherent clots, while clotted and fluid blood filled the pleural cavity.—*Lyon Méd.*, Dec. 19, 1886.

Ott (L.) on Two Cases of Extensive Extravasation from Traumatic Rupture of Large Blood-Vessels.—Mrs. R., tripped by a fold of the carpet, fell, striking her right shoulder. I saw her a few hours after the accident and found the shoulder-joint swollen, the least attempt at motion causing intense pain. I gave ether, and diagnosed a dislocation of the head of the humerus into the axillary space, with separation from its shaft by a transverse fracture of the surgical neck. I made an effort to effect reduction of the displaced parts, but failed. I then placed the arm in the most favorable position for the fracture to unite, with the intention of afterwards establishing a new articulation if necessary.

On the second day after the accident a marked ecchymotic discoloration appeared just above the upper angle of the axilla and gradually extended over the right breast, involving its upper three fourths; thence over the sternal surface and left breast, involving its greater part. This hemorrhage occupied a period of twelve days. While

the ecchymosis was appearing in the left breast, the upper third of the arm on its inner aspect began swelling and discoloring, and just as the hemorrhage had ceased travelling on the chest, it ran down the inner side of the arm and extended to the fingers' ends, lasting in all twenty-four days. The tenseness of the ecchymotic parts began subsiding, and no further hemorrhage took place. While the bleeding was progressing, especially over the chest, the radial and ulnar pulsations were in the beginning not perceptible, and later quite feeble. The temperature of the extremity was lowered. While the hemorrhage was progressing down the arm the blood on the chest was being absorbed.

In six weeks after the accident nearly all traces of the hemorrhage had disappeared, but over the spot where it first made its appearance there remained a hardened lump, which disappeared only after many weeks. I discovered no bruit or pulsation. She made a fair recovery, the fracture united, and the arm gained limited motion.

This case was evidently a laceration of an artery, produced probably during my attempt at reduction, or by the primary accident.

CASE 2.—Cabinet-maker, aged forty-five years, slipped on the ice and fell on his side. He quickly got up and walked thirty squares to his home, thinking himself unharmed by the fall. Ten minutes after reaching his home, while seated at the table, he felt a sudden, sharp pain in the outer middle third of the thigh, and when he attempted to get up to go to his bed he was unable to walk. He suffered severe, continuous pain the following night, occasionally having intense exacerbations.

I saw him the morning after the accident, and found a large, hard, tense swelling on the outer side of the middle third of the thigh, faintly fluctuating, very painful, and extending a length of seven inches; reaching within two inches of the knee-joint. The posterior border of the tumor terminated abruptly, owing to the obstruction offered by the intermuscular septa of the fascia lata dipping between the vastus externus and biceps muscles. The thigh could not be moved, owing to the painful tension caused by the tumor. The pulsations of the anterior and posterior tibial arteries were normal.

Drs. O. H. Allis and Bissey saw the case in consultation, and concurred with me in the

opinion that the tumor was due to hemorrhage from a ruptured vessel. I ordered rest and compression by a bandage. The next morning the swelling had extended to the knee, simulating the swelling of synovitis. There was no discoloration over the tumor.

On the fourth day ecchymotic discoloration appeared over the anterior tibial surface of the leg, and extended as far down as the ankle. At the same time the tension of the tumor began to subside, probably owing to an outlet having been found, which caused the leg-discoloration. He gradually improved till the tenth day, when a local elevation of temperature and fluctuation became more marked. Fearing supuration, I cut down on the tumor, turned out eight ounces or more of clotted blood, washed out the cavity, and closed the wound. The cavity was next to the shaft of the femur, between the bone and the overlying muscles. Its length was six inches, and its breadth three inches. After two weeks of absolute rest and compression, he made a good recovery, only having severe neuralgic pains of the anterior tibial nerve.—*Med. Times*, Aug. 21, 1886.

Neale (J. H.) on a Large Hæmatoma of Buttock; Aspiration.—One evening the patient, a woman of fifty, was leaning against the gate-post at the entrance of the yard, when a two-horse waggon turned into the gateway, and jammed my patient between the near fore-wheel and the gate-post. Since the accident she had complained of a dull aching pain in the region of the left buttock, which deprived her of any but the merest snatches of sleep. The bladder and rectal functions were normal. On the principle of exclusion I made up my mind that I had to deal with one of three things—(a) malignant tumor,¹ (b) gluteal abscess, or (c) hæmatoma (unabsorbed). The size and period of growth negatived the first, in addition to which I thought I could detect some obscure fluctuation. A subnormal temperature contraindicated the second alternative, so I made the diagnosis that there had been rupture of the gluteal muscles with deep-seated hemorrhage. An exploratory puncture with a fine trocar and cannula placed the matter beyond a doubt, several drops of serous fluid with flakes of fibrin oozing through the

¹ I have twice seen a sarcoma result from a hæmatoma following an injury, and have long regarded this as one of the "ultimate destinies" of blood-clot.

cannula. On Sept. 7th, after cleansing the parts with a 1 in 2,000 solution of corrosive sublimate (the discharge from the sore referred to smelling badly), I drew off a quantity of blood-stained serum (17½ oz., carefully measured) with flakes of fibrin in suspension. There was so little apparent diminution in the size of the tumor, that I felt convinced that all the fluid had not been evacuated, and reluctantly withdrew the needle, only to find it, as I had anticipated, plugged with fibrin. The patient expressed herself as much relieved, but in the course of a few days, the dull aching pain having returned, I aspirated a second time, removing 14½ oz. of fluid. Rapid resolution followed, and then the condition of the injured parts was plainly shown. Running downwards and inwards from the back of the great trochanter was a nodulated ridge, the contracted tendinous fibres of the gluteus maximus, which had been torn through close to its insertion, while the belly of the muscle hung as a flabby useless mass, giving an asymmetrical appearance to the buttocks. The patient made a rapid and complete recovery, with the exception that on flexing the trunk beyond a certain angle (as on stooping to pick up any thing from the floor) she was unable to regain the erect posture without the aid of extraneous objects, such as a chair or table leg; and failing these she adopted much the same tactics seen in children suffering from pseudo-hypertrophic paralysis, by climbing up her own thighs.—*Lancet*, Dec. 18, 1886.

Shepherd (F. J.) on the Disease Called "Ainhum,"¹ with the Report of a Case.—John B. S., æt. forty-seven, colored, native of North Carolina, and by occupation a teamster, was admitted into the Montreal General Hospital from Cornwall, Ontario, May 12, 1886, suffering from a painful toe which he wished to have removed.

History.—Six years ago he noticed a small pimple on the outer side of the right little toe in the digito-plantar fold. He did not suffer any inconvenience or pain from the affection till four and a half years ago, when he noticed a constriction on pressure appearing in the digito-plantar fold. The foot was then slightly swollen and the toe was somewhat enlarged. With

rest and poulticing the sore healed up and the pain and swelling of the foot disappeared, but the constriction remained and the toe continued enlarged. Four weeks ago the sore broke out again and the toe became very painful. The furrow, which had been increasing gradually, now rapidly deepened, and the portion of toe beyond became much swollen and pained him greatly when he walked. Patient has always been healthy and lived in North Carolina till twenty years ago. No member of his family, to the best of his knowledge, ever had a similar affection of the toes.

Condition on entrance.—Patient, a strong, healthy, full-blooded negro, complains of inability to walk much on account of the severe pain in the little toe of the right foot. Upon examination this toe is found to be very much constricted at the digito-plantar fold, the constriction almost completely encircling the toe—in fact, it looks as if a string had been tied tightly round it. The portion of toe beyond the furrow consists of a soft ovoid mass and is much larger than the normal toe. Nail quite healthy. The toe is very mobile and movement causes excessive pain. On the plantar aspect of the constriction is a small granulating sore which, on probing, is very sensitive. Foot not swollen. No other toe of either foot affected. Left little toe carefully examined and found perfectly normal.

On the 14th of May the toe was amputated at the metatarso-phalangeal joint, and the wound, under dry dressing and iodoform, rapidly healed.

On dissection the amputated toe appeared to consist of much thickened skin and fibrous tissue. Adipose tissue normal. The bones presented a remarkable condition. The proximal phalanx was much atrophied and ended in a fine point, the whole bone looking something like a claw; the joint between it and the middle phalanx had disappeared; the middle phalanx was much reduced in size and eroded at its proximal end; no distinct articulation could be made out between it and the ungual phalanx. This latter phalanx, though of proper length, was excessively thin and light.

The metatarso-phalangeal joint was perfectly healthy, though the end of the phalanx entering into the joint was somewhat lessened in size and misshapen, but the articular surface was of full size.

¹ This is the negro name for this affection. It means "to saw."

The disease called "ainhum" is one of great rarity; it is peculiar to the dark races, not only to negroes, as was formerly supposed, for it occurs also in India among the native Hindoos. Dr. Crawford¹ found that the disease was met with in about one out of every 2,500 surgical cases treated at his dispensary at Calcutta. In one of his cases the great toe was affected, in one the fourth toe, and in two the fifth toe. In no case was there any appearance of symmetry. The disease at one time was thought to attack the little toe only, but later observers have seen it in the fingers and even in the legs. It is said to occur in intra-uterine life, and to be the most frequent cause of congenital amputation.² In South America it is comparatively common in the African negroes, but rarer in those born in Brazil. It is said to be a common affection on the west coast of Africa.³ The disease was first clearly described by Dr. J. F. da Silva Lima, of Bahia, Brazil, in 1867.⁴ In the cases described by him the affection was confined to the little toes of adults, but lately others have described it as occasionally being seen in children, and also, as mentioned above, affecting other toes, fingers, and even limbs.

Dr. Silva Lima found the disease to be more common in men than women; it is also said to be more prevalent in certain families, showing its hereditary and, hence, constitutional nature.

Dr. Hornaday's case⁵ occurred in a negress aged ten. It is curious that the man whose case is narrated above is a native of North Carolina.

As a rule, the affection commences as a furrow on the line of the digito-plantar fold of the little toe; this furrow gradually deepens, and the end of the toe enlarges to double or treble its normal size, having a spherical shape. Generally there is no pain, inflammation, or ulceration, but when there is ulceration in the furrow, as in my case, the pain is excessive.⁶ As the furrow goes on deepening, it encircles the toe till the end is held by only a small pedicle. The toe does not lose its sensation, but

from its great mobility it is subject to injury and painful knocks, and the patient in consequence applies for relief. The toe is generally removed at the point of strangulation by knife or ligature. If left alone it falls off itself. The wound always heals rapidly. It is asserted that the disease can be arrested in the early stages by free longitudinal incisions cutting through the constricting fibres.

The course of the disease is very slow, lasting some eight to ten years. According to Silva Lima, the disease is usually asymmetrical, the affection in one toe being much further advanced than in the other. The phalanges atrophy and are replaced by fibrous tissue and the joints disappear. The skin is much thickened, and there is great hypertrophy of the papillary layer; the blood-vessels are also thickened and become larger.⁷

The cause of the disease is not known. The fact that sensation is not lost distinguishes it from leprosy, as does also its localization. It is probable from the great atrophy of bone which takes place that the disease is of nervous origin and is due to some trophic disturbance of the nerve centres. Microscopic sections of removed toes present no peculiar appearances.—*Am. Jour. Med. Sci.*, Jan., 1887.

Gibney (V. P.) on Fibrous Ankylosis at the Shoulder-Joint; Recovery.—A man without known cause, began to suffer from pains in his left shoulder. At times previous to May, 1885, he had had what he regarded as rheumatic pains. During the summer of that year the pains about the shoulder were aggravated by such movements as abduction and extension. There was no pain when the limb was at rest. The rotation was about one half the normal, and he could abduct the arm to an angle of 45° without tilting the scapula.

Early in September Dr. Gibney put the patient under the influence of ether, moved the joint in all directions freely, and determined to employ passive motion himself daily. He continued this until September

¹ *Edinburgh Medical Journal*, June, 1886.

² Stedman in Buck's "Reference Hand-book," vol. i., p. 91.

³ Dr. Rolf Leslie, who has lately returned from the Congo, where he spent two years, tells me that he never met with a case whilst there.

⁴ *Gazeta Medica di Bahia*, Anno I., No. 13, p. 146, quoted by H. Weber, *Path. Soc. Trans.*, 1867, vol. xviii.

⁵ *North Carolina Medical Journal*, September, 1881.

⁶ Dr. Crombie, *Indian Medical Gazette*, quoted by Dr. Crawford, in *Edin. Med. Jour.*, June, 1886.

⁷ Dr. H. Weber, *Path. Soc. Trans.*, 1867, vol. xviii., p. 279. In this article beautiful plates of microscopic sections are given.

23d, when the result was so unsatisfactory that he repeated the *brisement force* about one month later. The after-treatment in this instance consisted of rest and the application of fomentations for about ten days, when he resorted to massage and the use of the Paquelin cautery. At the end of a week the suffering of the patient had been increased, and his shoulder was much stiffer than when treatment was begun. During the next three months he did nothing in the way of treatment, suffered little or no pain, and at the end of that time his arm was more useful, the arc of motion was increased, and there was neither atrophy nor shortening nor infiltration. Now, nearly a year after the patient first came under Dr. Gibney's observations, the functions of the shoulder were perfect, and this result was not due to any particular mode of treatment. Whether the forced movements to which Dr. Gibney subjected the patient conducted to the good result, he was unable to say.—*N. Y. Med. Record*, Jan. 22, 1887.

Holyoke (F.) on a Simple Apparatus for Washing Out the Bladder.—An eight- or twelve-ounce glass bottle has its bottom cut off, and a cork perforated by two glass tubes is now introduced and sealed, to prevent leakage of air or water. To one glass tube, by five feet of rubber tubing, is attached a rubber catheter. To the evacuating tube is attached one foot of rubber tubing clamped by a bull-dog forceps or patent clothes-pin.

The safety of this apparatus lies in the fact that the evacuating tube reaches within the neck of the bottle one half inch beyond the injecting tube, so that, when held upright, there is no possible chance, while emptying the bottle through the former, for air to enter the latter.

Four pieces of cork held at regular intervals by a narrow rubber band prevent the bottle from rolling off the table, while the patient—either standing or seated—introduces the catheter; upon the entrance of which within the bladder the bottle is held and brought below the level of the bladder. The bladder being thus emptied, the forceps is removed from the evacuating tube, and all the urine passes into a vessel except the half thimbleful that remains in the neck of the bottle, to guard against the entrance of air within the injecting tube.

The clamp is now replaced and the fluid

to be used for injection is poured into the bottle which is slowly raised to a proper distance above the bladder, which gradually fills; the operator readily observing through the glass that it be not raised so high that the level of the fluid falls below the end of the short glass tube.

Having once introduced the catheter, this process of filling and emptying may be repeated as often as desired, without laying down the bottle, by the careful raising and lowering of which, the distension of, and pressure within, the bladder may be regulated.

In this apparatus we have no syringe, no tap to turn, no injecting nozzle which has to be repeatedly connected and disconnected with the catheter, and no doubt about its safety, for we see what we are doing.

A ready way to remove the bottom of a bottle is to file a groove, with a three-cornered file wet with turpentine, deep enough to hold in place a piece of strong twine. The twine is then drawn to and fro until the glass becomes hot. If now the bottle be immersed in cold water, the bottom separates along the filed groove.—*Boston Med. and Surg. Jour.*, Nov. 4, 1886.

Dobson (G. E.) on a Case of Transverse Fracture of the Scapula below the Spine.—G. J. was admitted to hospital suffering from pain in the right scapular region, increased by motion of any kind, and especially so by motion of the right arm outwards and forwards. While engaged in assisting to move a heavy iron target, he slipped and fell, and was immediately conscious of a sharp pain in the back of the right shoulder-blade, so much increased when he attempted to move the right arm that he was unable to continue to perform his duties.

On examination there was not the slightest sign of a contusion, or of any external violence. The form of the right shoulder and scapular region did not differ from that of the left. The patient was able to place (though with pain) the fingers of the right hand on the left shoulder. On moving the right arm outwards from the side, loud crepitus could be heard in the right scapula, and this with the aid of a stethoscope could be easily localized to the infraspinous fossa. The case was diagnosed as a transverse fracture of the body of the scapula below the spine.

The injury in question was evidently oc-

casioned by muscular force. The patient slipped when engaged in sustaining a heavy weight, and in trying to make good his foothold and also sustain the weight, the latissimus dorsi muscle was brought suddenly into violent action, when the inferior angle of the scapula, across which it extends, was also forcibly moved outwards and backwards against the tense body of the muscle, and, the upper part of the bone being fixed, fracture took place at a point between the opposing forces.—*Lancet*, Nov. 27, 1886.

Eames (W.) on Fracture of the Sternum.—A laborer, aged twenty-eight, sustained a fracture of the sternum on August 24th, caused by falling from the staging on which he was working on to the sharp edge of a piece of angle iron which was lying on the ground. He struck the iron with the front of his chest, the height of the fall being twelve feet.

On his being brought to the surgery, there was found to be a complete transverse fracture of the sternum on a level with the fourth costo-sternal articulation, and apparently through the point of cartilaginous union of the second and third pieces of the sternum. The upper and lower fragments were freely movable; but there was little or no displacement, the seat of fracture being visible in the form of a slight angular protrusion, the ends of the fragments being tilted slightly forwards. The soft parts over the seat of fracture were much contused, and there was slight emphysema. The crepitus elicited by motion of the fragments was of a soft cartilaginous character, pointing to the evident position of the fracture. The fourth rib on the right side was also found fractured a small distance from its costo-sternal articulation. No other injuries could be detected. There was great dyspnoea, the fragments moving slightly during respiration. The heart's apex-beat could not be detected by digital examination.—*Brit. Med. Jour.*, Nov. 20, 1886.

Porter (W. T.) on a Case of Extensive Superficial Burns; Subnormal Temperature; Suppression of Urine; Death.—An American negress, thirty-four years of age, said that the gasoline with which she had been cleaning a dress had exploded and set fire to her clothing. She was found to be burned over the whole body, excepting the ankles and the feet. In a number of places the

integument was entirely destroyed, but the deeper tissues were nowhere charred. She complained of severe pain, and was very restless. Morphine and stimulants were administered, and every three hours her entire body was anointed with a five-per-cent. solution of carbolic acid in boiled linseed oil.

Five hours after admittance she had passed no urine, and on using the catheter the bladder was found to be empty. Four hours later the patient was again catheterized, and a small quantity of pale, non-albuminous urine was withdrawn. She passed a restless day and died at dark.

The temperatures which were taken are trustworthy.

Sept. 11th.	In mouth.	In vagina.	Respiration
11:45 A.M.	34° 3' (93° F.)	34° 7' (94° F.)	
1:40 P.M.	33° 9' (92° F.)		30
3:15 P.M.	32° 9' (91° F.)		38
4:45 P.M.		34° (93° F.)	43
6:55 P.M.	32° 4' (90° 3 F.)	33° (92° 6 F.)	47

—*St. Louis Med. and Surg. Jour.*, Jan., 1887.

Abbe (R.) on Trigger-Finger.—The case was a girl, ten years old, in whom, on her closing the right hand and then opening it, all the fingers were straightened except the little one, which remained flexed, but could readily be straightened with the other hand. In this case, as in one other of the five cases that he had seen in all, there was a nodule on the flexor tendon; all of them had shown a slight thickening of the sheath. In one case the treatment had consisted in encircling the middle of the finger with a band, to prevent it from closing to the catching-point; and by thus preventing irritation of the node in the sheath of the tendon, the finger had been perfectly restored to its normal condition. He was now trying the same treatment in the other cases.—*N. Y. Med. Jour.*, Dec. 4, 1886.

An Artificial Ramus and Condyle.—At the last meeting of the Odontological Society, Dr. Cunningham showed a very ingenious apparatus invented by Herr Rosenthal, which was designed to meet the following difficulty. The ramus and condyle of the lower jaw having been removed for a sarcoma, it was subsequently found that the other side became dislocated, and, after reduction, for which an anæsthetic was required, slipped out again immediately. Gold bands were fitted accurately

¹ See MEDICAL ANALECTIC for July, 1886, p. 310.

to the last molar of each jaw on the side where the bone had been removed, to the upper of which a thick, slightly curved wire was soldered. This wire fitted loosely into a tube soldered to the band round the lower tooth, and the bands themselves were fixed to the teeth by screws tapped into them. The apparatus entirely prevents the dislocation, and although there is no lateral movement the patient can eat fairly well.—*Lancet*, Dec. 25, 1886.

SYPHILIS.

On Albuminuria Coming on during the Secondary Stage of Syphilis.—

From four personal observations and his study of the subject, E. Wickham¹ concludes that syphilitic albuminuria in the secondary stage is usually benign, rapidly disappearing under the influence of mercurial treatment. The albuminuria *a frigore* coming on during the secondary stage is serious, and not amenable to mercurial treatment. Syphilis developing in a Bright's person is exceptionally serious, because of the new renal lesions which may be super-added to the old. From the standpoint of pathological anatomy, renal syphilis of the secondary period is an interstitial nephritis.

Horteloup,² also from a study of four cases, concludes: That syphilis in its early stages (months) can cause albuminuria; that it quickly yields to specific treatment and leaves no trace; that it should be distinguished from the albuminuria in the second or third year of syphilis, which is much more serious and denotes the advent of a chronic nephritis. It should not be lost sight of that a syphilitic is always of lowered vitality and much more predisposed to catching cold or to contracting a nephritis *a frigore*.

Spillmann (P.) on Syphilitic Aneurism of the Cerebral Arteries.—In the first place, the author considers syphilitic cerebral aneurism a rather common pathological condition. The basilar and sylvian arteries are its seat of predilection. They nearly always terminate in rupture, with a train of symptoms like meningeal hemorrhage. As a rule, they occur in cases of long-standing syphilis, but they may be precocious and develop a few months after infection. Cases imperfectly

treated or left to themselves are more predisposed to cerebral vascular lesions. The liability to such lesions should teach physicians to act quickly and heroically in cases where syphilitic cerebral arteritis is suspected.—*Ann. de Dermat. et de Syph.*, Nov. 25, 1886.

Lloyd (J.) on Spurious Venereal Diseases.—The author concludes from a study of sixteen cases, all males;

1. That a large number of urethral discharges in the male, although sexual in their origin, are not specific.

2. That many penile sores of sexual origin are neither chancres nor chancroids.

3. That idiosyncrasy plays an important part in the contraction of venereal diseases of all kinds.—*Birmingham Med. Rev.*, Oct., 1886.

Porter (W. H.) on Syphilitic Changes in the Lungs.—

Dr. W. H. Porter, at a recent meeting of the N. Y. Pathological Society, presented a lung which contained several tumors believed to be syphilitic gummata. He also exhibited a pair of lungs which were the seat of very extensive infiltration by the same material. Examination for the tubercle-bacillus had been carefully made, but without finding it. The clinical history in these cases showed scarcely any, if any, elevation of temperature, and this fact he attributed to the marked thickening of the alveolar walls throughout the lung, preventing entrance of the broken-down material into the lymph-sacs (with attending septic fever) and directing it into the bronchi; hence also the profuse expectoration. In tuberculosis the fever was due, he thought, to the easy access of the pus into the lymph-vessels, causing septicaemia.—*Med. Times*, Jan. 8, 1887.

Lemonnier on Syphilis Transmitted from Child to Nurse and from the Nurse to her Husband.—

A woman of fifty-four took two babies to nurse, one dying at the twenty-sixth month, the other in the second month. Four days before the last child died, the nurse had sore throat, headache, chilly feelings, and general weakness. Four weeks later a rash came out on her forehead, chest, and back. When seen she had small ulcerating syphilides of the right labium major, and a syphilide like a mucous patch near the inner canthus of the right eye, with a posterior synechia in the same. The husband, who had very infrequent intercourse with his wife, con-

¹ *L'Union Méd.*, Oct. 24, 1886.

² *L'Union Méd.*, Nov. 23, 1886.

sulted Lemonnier for a hard chancre of the prepuce, an impetiginous eruption in the scalp, a papular syphilide on the chest, and a papulo-squamous syphilide on both legs.—*Ann. de Dermat. et de Syph.*, Oct. 25, 1886.

MISCELLANEOUS.

Keirle (N. G.) on Cryptorchidism in an Adult.—It occurred in a robust adult negro of about forty years of age.

There was a penis of normal size, and the scrotum was developed in accordance, but it did not contain testicles. This subject is said to have been the father of two children.

At autopsy (the man being drowned) there were found within the pelvis two apparently well-developed testes, the one adherent to the bladder and the other to a loop of small intestine in such a way as to suggest the relation borne to the uterus by the ovaries. The vasa deferentia, seminal vesicles, and prostate were all apparently normal. No spermatozoa were found in the seminal vesicles at the examination made twelve hours after death.

The testes measured in their long diameter three to four cm., and in their transverse diameter about three cm.

Microscopic examination of one of these testes, made by Dr. A. C. Abbott, showed a decided increase in the amount of fibrous tissue in the organ. These changes were so far advanced as to justify the opinion that a testicle in this condition could not possibly perform its normal functions.—*Maryland Med. Jour.*, Jan. 8, 1887.

Fenwick on Carcinoma of the Prostate.—The case was one of carcinoma of the right lobe of the prostate in a patient aged fifty-one. The first symptom, which was observed some weeks before death, was some difficulty of defecation. A large tumor of the prostate was found projecting into, and partially obstructing, the rectum. It rapidly increased, ulcerated, and fungated. The urethra and bladder were uninvaded, but the catheter had to be used. Lumbar colotomy had to be performed on account of obstruction of the bowels, to the great relief of the patient.—*Provincial Med. Jour.*, Dec. 1, 1886.

Jackson (L. D'A.) on the Deadly Manzanilla.—The tree known in Venezuela as the Manzanilla (apparently not connected in any way with manzanas or

apples), had the reputation of causing death to those inhaling the air close to it. By way of preliminary I may mention that the papao tree of India and of Mexico, even when of very scanty foliage, emits sufficient vaporous matter to render a very tough leg of mutton quite tender in two or three hours, and to render it putrescent in a comparatively short time. My prejudices, therefore, led me to expect something similar in the manzanilla, or perhaps something analogous to the yew-tree whose leaves are deadly to cattle, and whose exudations have perhaps also done harm to human beings in many uninvestigated cases.

I had to deal with a group of manzanillas said to occur on a projected line of railway several years ago. Portions of this line had been made about six years before that, and abandoned. One of these portions stopped within half a mile of the group; how far the death of so many workmen was attributable to the influence of these trees is now mere conjecture, because the twenty-five English navvies might have all succumbed to their own habits, want of tubbing, indifference as to diet, excess in drinking, etc., etc., as well as to the ordinary malarious or marsh fevers of the locality. I may mention that though these utterly wreck and permanently ruin the human constitution, they do not kill direct otherwise than in a moderate percentage of cases.

On a visit to the group of manzanillas, these were found bordering a sheltered hollow within a hundred yards of the sea. They were about fourteen in number, mostly luxuriant large trees, about the size of an average full-grown British elm, and slightly resembling them in the clustering of foliage. The leaves had a little of the semi-transparency of lime or linden leaves, the grouping of leaves rather resembling that of the chestnut, the leaves indented like the plane or the currant leaf; the trunk and branches well formed, bark rather smooth, but greenish perhaps from moss.

On the whole they were handsome and so well grouped and intact that one wished to stop and sketch them, though the stagnant air of the place was unpleasant, apart from the risks attending its inhalation. Vegetation flourished in the neighborhood, though grass did not grow absolutely under the trees; but the absence of any mangrove thickets about there was noticeable.

The arrangements made with the agent

for their removal were these : that the suitable season should be chosen, and the trees burnt down from the windward side during a favorable prevalent wind, bundles of brushwood to be rolled close with long poles and fired, the supply of which was to be large ; the men employed were to have all their requirements as well as their superstitions attended to, besides to be covered and protected by leather all over, also to be provided with masks and gloves.

The agent, now dead, adhered to this proposal and carried it out in my absence on other work in the interior. On one of my visits to the coast, he informed me that almost all those trees had been burnt ; about eighteen men had been engaged in it, four or five had died, almost all had been ill. I saw one of them who had come about a hundred yards for assistance, about ten days after leaving that work.

He was emaciated, and complained of pains in his limbs, which apparently were of a paralytic nature ; he had also had very severe fever, and was apparently quite worn out.

After his departure, the agent said that he considered recovery hopeless in that case, as well as in all the cases of men that had been so employed throughout the undertaking, but that some of the men who had been employed only latterly and for a short time might survive the attacks, which did not at all resemble those of the local fever. He also considered that all the paraphernalia for personal protection had been entirely useless, and had imagined so from the beginning, as he had lived in Mexico and had had some previous knowledge.

The deadly influence of the manzanilla is hence no myth ; it evidently produces a special paralytic fever, or combination of paralysis and fever.

There are also several other poisonous trees in the province. In one case, an estate manager after a journey was seized with severe pains in the head, followed by swelling of the head to a very large size, though apparently there was neither scratch nor bruise. He was treated medically and soon recovered entirely ; but the assigned cause was simply the brushing of some branches of a tree or shrub (name unknown) against his head while riding on the journey.

The cases already mentioned cannot, in my opinion, have been attributable to other causes. The local fevers, of which the

whole of my workmen were victims (myself a very persistent smoker the only exception), are of a depressing and virulent type, and intermittent.

The result of getting wetted in a stream or river, without subsequent rubbing dry, is sure fever of the same sort, but is specially fatal. In fact, the rivers appear to be poisonous on outward application. Damp feet from marsh-wading in my own case produced malignant eruptions ; at another time I had three days' mild fever from accidentally slipping on the bank of a stream and wetting my head and arm in the fall.

Apparently none of the ordinary local maladies include paralytic or any analogous symptoms. The other causes of death are swarms of wasps and bees, and the stinging of sand flies and mosquitoes, which cause at certain seasons very severe fever, sleeplessness, with sometimes a fatal termination. The rattlesnake, coral snake, and other poisonous snakes, are abundant ; the guinea worm sometimes causes the loss of a toe ; the *anaconda* is plentiful and sometimes magnificent ; the harmless green tree snake is very slender but attains 24 feet in length. The *mato reale*, an enormous true lizard, I saw, but I will not here mention its size, lest a traveller's tale should be treated as a printer's error.—*Medical Press*, Oct. 13, 1886.

Letulle (M.) on the Lesion of Peripheral Nerves in Mercurial Poisoning.—Localized mercurial paralyses, according to Dr. Letulle, indicated material, circumscribed lesions of peripheral nerves. The symptoms of these paralyses differ from those of lead paralysis by the preservation, in the former, of normal electrical contractility, absence of atrophy, and the persistence of tendon reflexes. The mercurial lesion consists in progressive destruction of the myelin with indefinite preservation of the axis-cylinders. These trophic changes are pigmentary and periaxile.—*Le Courrier Méd.*, Jan. 15, 1887.

Tait (L.) on a Case of Menstruation after Removal of Pregnant Uterus and Appendages.—E. P—, aged thirty-three, menstruates somewhat profusely at irregular times, and has done so twice in the last three weeks. This has continued since I removed the uterus (at the fourth month of pregnancy) in August, 1884. A large soft sarcoma grew from the fundus, and the whole uterus was infiltrated with nodules of the same growth ;

therefore the clamp was made to include as much of the organ as could be pulled up, and I believe the whole of the organ was removed. Previous to the operation she tells me that she never had any sexual enjoyment, but that now she has it occasionally. The vagina is now (Nov. 22, 1886) greatly elongated, and a small pimple can be felt at the upper end of it, in the cicatrix.—*Lancet*, Dec. 18, 1886.

Tait (L.) on Accidental Amputation of Inverted Uterus.—Mr. Lawson Tait read the notes of a case in which a large soft villous polypus was found occupying the vagina in a woman aged fifty-two. This was removed with an *éraseur*, when it was seen to be the inverted uterus covered with a layer of soft villous epithelioma. An india-rubber drainage-tube was passed into the peritoneal cavity through the wound, and the patient kept perfectly quiet. Recovery took place in about a fortnight. The growth of the villous endometric epithelioma had probably caused inversion of the uterus by dilating the cervix. The true nature of the case was not discovered until the operation had been performed. Such cases were very rare, but one had occurred in the practice of Mr. Alfred Baker, in which the uterus with a myoma in the fundus, which had been the cause of its inversion, was accidentally removed in the same way as in the case just related. The operation was the only thing that could have been done, and though accidental, no other treatment would have had any thing like so successful a result.—*Brit. Med. Jour.*, Jan. 8, 1887.

Bennett (E. H.) on Simultaneous Fracture of Both Clavicles.—A cast was submitted exhibiting this lesion, taken from a man, and also the clavicles of a little girl, æt. six, who had sustained a complete fracture of one clavicle, and an incomplete fracture of the opposite, by being run over by a tram-car. In the first case perfect union had been obtained in both fractures, with but little deformity—a fact of importance, seeing that out of eighteen cases collected by Gurlt, no less than eight had resulted in non-union of the fractures—a result clearly attributable to the difficulty of maintaining the parts at rest in such an injury without the most careful nursing.—*Medical Press*, Jan. 5, 1887.

Bennett (E. H.) on Injuries to Costal Cartilages.—On the right side, the

second, the third, and fourth cartilages were broken transversely, while the first was dislocated from its rib. On the opposite side one of the lower cartilages had been also dislocated from its rib, and one had sustained a partial fracture. Dr. Bennett directed particular attention to the dislocation of the cartilages from the ribs, as the occurrence of such dislocation had been denied by Malgaigne.—*Med. Press*, Jan. 5, 1887.

Mastin (W. M.) on Venous Blood Tumors of the Cranium in Communication with the Intra-Cranial Venous Circulation, Especially the Sinuses of the Dura Mater.—Palliative measures for retarding or arresting the progress of the growth, and certain forms of compression intended to act as a curative agent, are useless applications.

General surgical interference is not called for, because the history, nature, and progress of the lesion is opposed to indiscriminate operation; being of that character to render such treatment unnecessary. When, however, operation is deemed expedient or is demanded, the following methods seem to be open for adoption:

First, if the growth be either of the diffused type, or that form consisting of a parix-sinus, exposure and ligation of the vedicle (if such exist), or, if necessary, deligation of the sinus in its course, the trephine being boldly employed to furnish requisite space for the necessary attending manipulation. The lateral ligature and suture, when applicable, are preferred to complete ligation.

Second, if the tumor be composed of varicose emissary vessels, or, perhaps, of diploic dilatations, either electro-puncture or strangulation of the base are justifiable procedures, but preference is given to electro-puncture.—*Jour. Am. Med. Ass'n*, Sept. 18 and 25, 1886.

Jackson (H.) on a Rare Form of Epilepsy.—The case was that of an infant, who at three days of age had a convulsion. At the age of two and a half years the child had a second fit, described by the doctor in attendance as an ordinary epileptic fit, lasting over an hour. Since then the child has had four similar attacks. From the date of his first fit, the use of the left arm and leg has been imperfect, and for six weeks before the first observed epileptic fit at two and a half years of age he became subject to unaccountable falls,

probably of the nature of a convulsion. The most curious feature in the case was the ease with which these fits could be brought on by simple pressure on any part of the head or face. It was scarcely possible to ascertain whether consciousness was lost during the attacks, which were only of a few seconds' duration, but it was noticed that the boy did not seem merely to *fall* but rather to be pulled down by a spasmodic muscular contraction. These fits could be brought on during sleep by pressure, and were sometimes accidentally determined by mere contact.

Dr. Hughes Bennett alluded to the case of a man who, after a blow on one side of the head, had epileptic attacks preceded by peculiar visual aura. The fits were severe, and were followed by acute mania, which led to the patient's detention in an asylum. The fits could be evoked by pressure on the site of injury corresponding to the angular gyrus. Six years after the first onset of the fits, Mr. Pearce Gould, at Dr. Bennett's request, trephined over the spot, but nothing abnormal could be discovered either in the dura mater or brain substance; a probe was passed into the brain in several directions without any thing being found. The man made a good recovery and, curious to relate, had no more fits.—*The Med. Press and Circ.*, Nov. 17, 1886.

Bewley (H.) on a Parasitic Disease of Lungs of Sheep.—In the lungs of several sheep which were examined lately in the Physiological Laboratory of Trinity College, Dublin, a number of whitish or grayish nodules were scattered through them, varying in size from $\frac{1}{8}$ to $\frac{1}{4}$ inch in diameter. On microscopic examination these nodules proved to be caused by a small nematode worm, from 15 to 17 mm. long, and extremely slender. The worm lay coiled up in the interior of a mass of apparently dried purulent matter. This mass was surrounded by a zone of elongated epithelioid cells, arranged in a radiating manner round the central mass. The epithelioid cells were embedded in a delicate fibrous reticulum; and here and there large giant cells were seen. Around these radiating cells was a zone of small lymphoid cells, embedded in fibrous tissue, and arranged in concentric layers. Outside these cells, in some of the specimens, was healthy lung tissue. In others the nodules were surrounded by catarrhal pneumonia. The

worms in these nodules have no reproductive organs, and are apparently immature forms of *strongylus filaria*—a nematode worm that inhabits the bronchi and trachea of sheep and goats.—*Med. Press*, Jan. 5, 1887.

Pryer on Myxœdema.—The patient was a woman, aged fifty-seven. The disease was about twelve years' standing, and there was a history of excessive child-bearing, miscarriage, and flooding. The patient had also experienced considerable mental worry. The case presented the following characteristics: Considerable hebetude; general slowness of the various movements of the body; renal aspect of face; slow, monotonous speech; resilient œdema of a translucent character in some parts of the body; slow pulse, 65; subnormal temperature, 96°, 97.6°, etc.; dry, harsh condition of the cutaneous surfaces; filling up of the inferior triangles of the neck with superfluous tissue; and aberrations of the special senses of smell and taste. The urine was acid (specific gravity 1012), and did not contain albumen, sugar, or peptone. The excretion of urea was diminished—that is, 1.188 per cent. Muscles reacted to the interrupted current. The symptoms varied in accordance with the surrounding temperature.—*Brit. Med. Jour.*, Jan. 1, 1887.

The Abortive Treatment of Felons.—Dr. Fish,¹ of Amherst, uses collodion. Five or six coatings should be applied half-way round the finger, and the application is to be repeated whenever the film of collodion breaks or begins to peel off; if applied entirely around the finger the contraction will cause unbearable pain.

I have used the contractile collodion with success in effusions of the knee, in œdema of the hand after fracture of the arm, and in the protrusion of the umbilicus in infants.

I have also used it to hasten the absorption of extravasated blood, especially upon the face and eyelids, after injuries.

Dr. Williams,² of Roxbury, in the earliest stage, ties a rag loosely around the finger and keeps it constantly wet with cold water. It cures often; but probably some more fantastic appliance will better please most patients, and give them a higher opinion of the surgeon's skill.

Bloxam (J. A.) on Movable Body in Bursa Patellæ.—Lucy T., 31, servant,

¹ *Boston Med. and Surg. Jour.*, Nov. 11, 1886.

² *Boston Med. and Surg. Jour.*, Oct. 28, 1886.

six months ago noticed a slight swelling over the left patella which gradually increased in size, accompanied by a burning pain; she became unable to kneel to do her work. On admission, examination revealed the presence of a semilunar body, some three quarters of an inch long by a quarter of an inch wide, in the bursa over the left patella. It was freely movable. Pressure upon it does not hurt her, but pain of a lancinating character comes on shortly afterwards. It is firm and elastic to the touch. She feels pain on flexing the knee, but none when the leg is extended.

Nov. 29th.—Mr. Bloxam removed the body under strict antiseptic precautions. On making a cut into the bursa the body at once came into view, and on passing the handle of the scalpel beneath it, it was found to be attached at both ends, but free in the middle. The bursa was thickened, showing traces of previous inflammation. It was then carefully dissected out and removed in its entirety. Due provision was made for drainage, and the wound was closed and dressed with antiseptic gauze. The leg was then placed on a straight back-splint. There was no hemorrhage of any importance. The body removed was somewhat the shape of a bridle-piece, and was probably of organized lymph. Temperature (evening) 99° F. The patient was discharged cured Dec. 11, 1886.—*Medical Press*, Dec. 29, 1886.

Sympson (T.) on Myositis Ossificans.—C. A. M., aged six years, first came under my care on March 27, 1885. He is fairly well developed, is of light complexion, with light-brown hair, and blue eyes.

He complained of much pain about the right shoulder, and inability to separate the arm from the side. The shoulder and region of the scapula were extremely tender to the touch, and it was difficult to insert a finger into the axilla. There was no movement in the right shoulder-joint, and the movements of the left were much restricted. The dorsum of the right scapula, below the spine, was occupied by an elastic nodulated tumor, four inches by three, and in the situation of the long head of the right triceps was a similar tumor, two inches by one. The tendons of latissimus dorsi and teres major were extremely tense and rigid. On the dorsum of the left scapula, below the spine, was another tumor, three inches by two. The gait of the boy was peculiar; he walked with his chin advanced, and his

shoulders thrown forwards. The skin was cool and moist; temperature normal; pulse 84, regular; the tongue was clean; bowels open.

The history I obtained was that, with the exception of his having passed through an attack of measles favorably when two years of age, the boy had always enjoyed good health. During the last week of October, 1884, while running, he fell upon the pavement and hurt his right shoulder, a week after which a painful swelling formed over the scapula; this gradually shrank, and then, three months after, a similar swelling appeared over the left scapula. In March, 1885, his parents took him to a bone-setter at Grantham, who said that the shoulder was "out," and gave them some liniment to rub it with, the application of which, it is scarcely needful to say, did not effect any improvement.

The boy is the subject of a curious malformation. The head of each first metatarsal bone is large and prominent, and the great toe on either side is small, apparently consists of only one phalanx, and is directed towards the outer border of the foot.

He has two sisters alive and healthy, aged respectively eighteen and sixteen. His father, a fitter in a foundry, is somewhat rheumatic; he presents the same congenital deformity of his great toes as his son. His mother is alive and healthy. His maternal grandfather is said to have died of cancer of the chest. His paternal grandparents both suffer much from rheumatism.

He was ordered to take two grains and a half of iodide of potassium, and five grains of citrate of iron and ammonia in two drachms each of chloroform-water and water, three times a day.

On April 20th, the note was: "The tumors have become shrunken, and are firmer, and more distinctly nodulated. He can separate the arm further from the side, so as to admit of the easy insertion of a forefinger into the axilla from behind. The growths are free from pain, and no longer tender. A growth the size of a hazel-nut has now formed over the posterior superior spine of the right ilium."

May 20th.—The tumors continued to shrink. There was a fresh one of the size of a walnut over the angle of the eleventh left rib.

June 22d.—The tumors were decidedly smaller and much harder. A fresh growth, rounded, firm, and elastic, in size equal to

a hazel-nut, had appeared over the angle of the twelfth right rib.

July 21st.—A swelling of the size of a walnut was now perceptible in the margin of the trapezius a little below the occiput on the left side, and a similar one about the middle of the neck, in the margin of the muscle, on the right side.

August 20th.—A fresh tumor, $4\frac{1}{2}$ inches by $2\frac{1}{2}$ inches, had formed in the border of the latissimus dorsi in the left loin. All the other tumors were becoming less, and were firmer and more distinctly nodulated.

September 28th.—No fresh growths had appeared.

November 26th.—All the growths were shrinking.

December 16th.—The growths continued to diminish.

January 8, 1886.—The boy was shown by Mr. Hutchinson at a meeting of the Clinical Society of London, when it was noted that a saddle of bone covered the loins, and rendered the boy incapable of stooping, and that the margin of each latissimus dorsi, the teres major on each side, and the long head of the right triceps, were occupied by a series of lumps which were apparently bony, and that similar lumps were present a little below the occiput in the trapezius on the left side, in that muscle in the middle of the neck on the right side, and in the supra-spinous fossa. The movements of the head and neck were not interfered with.

January 14th.—The back of the boy and his feet were photographed by Mr. Hadley. At the suggestion of Sir James Paget, the boy was put upon three minims of arsenical solution, and half an ounce of infusion of gentian twice a day.

March 18th.—There was now a soft elastic prominence, four inches by three, between the dorsal spine and the base of the left scapula, apparently implicating the rhomboid muscles, and the swelling in the latissimus dorsi between the last left rib and crest of the ilium was more pronounced. The boy was free from pain. On examination with the ophthalmoscope, the fundus of each eye was seen to be normal.

July 20th.—A boss, of the size of a walnut, had formed midway between the

spine of the left scapula and its inferior angle. The new-formations in the rhomboid muscles and in the left loin had become flattened and smaller.

Circumference of chest at level of nipples, after expiration, 23 inches.

Circumference of chest at level of nipples, after inspiration, $23\frac{1}{2}$ inches.

Circumference of abdomen at level of umbilicus, after expiration, 22 inches.

Circumference of abdomen at level of umbilicus, after inspiration, 23 inches.

July 20th.—The urine was of specific gravity 1,020, acid reaction, yellowish-red color. It contained no albumen, nor sugar.

With regard to its diagnosis, there can be no doubt that the case is one of myositis ossificans, presenting, as it does, the characteristic features of that disease, namely, the formation of nodules in certain muscles in successive groups, the nodules being at first tense and elastic, but subsequently becoming hard and contracted, or even wholly disappearing; the occurrence of periodical pauses of various duration in the symptoms, and the slowness of the course of the disease.

The question naturally occurs to the mind of the observer whether, in such cases as this, the new formations that are present are composed of true bone, or whether the soft material first exuded has simply become calcified. The answer to this is that, in Dr. Kümmell's¹ case, a portion removed from the axillary line was undoubtedly bony, and that the results of *post-mortem* examinations in von Münchmeyer's,² von Gerber's,³ Testelin and Danbressi's,⁴ and Rogers'⁵ cases go to prove that the tumors are made up of true osseous tissue.

In a case related by Dr. Helferich,⁶ as well as in one by Partsch,⁷ the presence of a peculiar congenital deformity, both of the great toes and of the thumbs is noted. It is worthy of remark that a similar deformity is present in the case under my care, and also in a case shown by Mr. Godlee at a meeting of the Clinical Society on May 28, 1886, but in these it is limited to the great toes. Whether such malformations are to be regarded as mere co-

¹ *Archiv für klinische Chirurgie*, Band xxix., 1883.

² Mays in Virchow's *Archiv*, Band lxxiv., S. 145, 1878.

³ *Dissertat.*, Würzburg, 1875.

⁴ *Gazette Médicale de Paris*, 1839, p. 170.

⁵ *Amer. Journal of Med. Sciences*, vol. xiii., p. 386, 1883.

⁶ *Aerzt. Intelligenz-blatt*, 1879, No. 45.

⁷ *Breslauer Aerztliche Zeitsch.*, 1882, No. 6.

incidences, or whether they denote that the disease is due to some development, must, I think, be as yet considered uncertain, the cases hitherto reported being too few in number to allow any definite inference to be drawn from them. It is, of course, quite possible that no true relation may exist between them.

In some cases,¹ as in the one just related, it is noteworthy that there has been a distinct family-history of rheumatism; but here again the evidence is too limited to permit of any certain inference being obtained, and the same remark may, perhaps, apply to the influence of injuries which seemed to have been the exciting cause in my case, as well as in cases reported by Partsch, Münchmeyer,² and Testelin and Danbressi,³ although the history of the development of the so-called "drill-bone" in soldiers of the old Prussian army, and ossification of the origin of the adductors in hard riders, appear to point somewhat in this direction. In other instances, severe cold, or severe muscular exertion, have appeared to be exciting causes of the disease.

Mays⁴ considers that the "sudden occurrence in early youth in a previously healthy person, the extraordinary symmetrical localization of the process, and the great analogy between the several known causes, speak for the opinion that congenital predisposition has much to do with the occurrence of the disease." A recent writer, Pinter,⁵ is of the same opinion, and the other conclusions he has arrived at, which I may here quote, are, "that, in the spinal cord, no pathological changes can be detected, and microscopical examination of the cord and of the peripheral nerves shows no histological changes. The hereditary theory must be dismissed." He does not think injury the cause, and points out the frequency of injuries to children, and the rarity of the disease. Of twenty-two cases he has collected, ten were in Germany, six in England, two in America, and one each in Austria, France, Russia, and Switzerland. He does not think therapeutic agents of any avail.

The *Pharmacopœia* has been drawn upon largely in the treatment of these cases. There have been applied locally blisters, iodine, mercurial ointment, induced cur-

rent of electricity, ice, and local bleeding. Internally have been administered colchicum, iodide of potassium, cod-liver oil, sarsaparilla, mercury, calomel, and opium; baths and mercurial treatment alternately employed; nitric acid, phosphoric acid, lactic acid, and, in one case, astate resembling scurvy was attempted to be produced by subsistence upon a salted diet.⁶

All these methods of treatment have proved futile; or, if any benefit has appeared to have resulted from them, the amendment has probably been due to a remission in the ordinary course of the disease rather than to the efficacy of the measures adopted.

With reference to the age and sex of the patients, it is stated in Seidel's treatise, in Gerhard's *Kinderkrankheiten*, Band v., Abth. 2, that, out of 22 cases where age is given, 15 were under and 7 over 15 years of age; these latter did not live beyond 20; 4 of them were soldiers. In 24 cases only 5 were females. The prognosis must be looked upon as bad, the patients usually dying from some intercurrent pulmonary affection.—*Br. Med. Jour.*, Nov. 27, 1886.

Pulverized Spleen in Chlorosis.—

The German medical papers quote some observations made by Dr. Predazzi at Prof. Maragliano's request, on the value of treating chlorotic patients with an emulsion of pulverized spleen, bitter almonds, and brandy. In the five cases in which this was adopted, rapid improvement took place both in the general condition of the patients and in the physical signs; that is to say, the number of red blood-corpuscles was increased, as also the arterial tension and the body-weight. The author does not attempt any explanation of the action of this singular remedy. The quantity of "polp. splenic" given daily was about five ounces, and it was ordered at meal-times.—*Lancet*, Jan. 22, 1887.

Acrobats and Science.—M. Guyot-Daubès, in a work entitled "*Hommes-Phénomènes*," enumerates the services rendered to science by the class of acrobats known as sword-swallowers. Owing to the amiability of an acrobat, Stevens, in 1777, was able to study the human gastric juice. For this purpose, he placed small quantities of meat in metallic tubes pierced with

¹ *Gazette Médicale de Paris*, 1839, p. 170.

² *Zeitsch. rat. Med.*, Band xxxiv., 1869, p. 9.

³ *Gazette Médicale de Paris*, 1839, p. 170.

⁴ *Virchow's Archiv*, Band lxxv., 1878, p. 145.

⁵ *Inaug. Diss.*, Würzburg, 1883.

⁶ Rogers in *American Journal of Medical Sciences*, vol. xiii., 1833, p. 386.

holes, which the acrobat swallowed and brought up again when directed. Sword-swallowers have demonstrated how instruments for facilitating swallowing must be adapted. Fauche's tube is based on their information; also the construction of œsophageal catheters, for injections into the stomach, and the invention for illuminating the stomach with the electric light. In a word, acrobats are unknown benefactors to science.—*Br. Med. Jour.*, Jan. 22, 1887.

Aitkin (C.) on Mumps, Orchitis, Rheumatic Fever, Chorea.—About a couple of months ago I was called to see a boy, aged twelve who was suffering intense pain in the left testicle. On examining the patient, I found that he was recovering from an attack of mumps, and as there was no other obvious cause for the pain, I came to the conclusion that this was a case of metastatic inflammation in the testicle.

The pain soon yielded to a course of poultices. Hardly had the pain left and the patient expressed himself better than a rather severe attack of rheumatic fever set in, with pains in the joints, but without any heart mischief. The boy was then treated with salicylate of soda, with much benefit, and was free from pain in five or six days' time.

On the sixth day, at my morning visit, I noticed that the boy was jerking his hands and arms about, would laugh without any reason whatever, and had some slight difficulty in answering my questions; in fact, he had an attack of chorea, which was more marked on the right side than the left.

I then gave him arsenic and iodide of potassium, and after a few days he was convalescent, but rather weak. Since that time I have occasionally seen the patient, who is progressing favorably, but slowly. The curious part of this sequence of diseases is that the mumps was followed by the inflammation of the testicle, which is rather rare, and that the rheumatic fever should have been succeeded by the attack of chorea.—*Br. Med. Jour.* Jan., 22, 1887.

Micro-Organisms in Air.—In a recent communication to the Royal Society, Dr. Percy Frankland described a new method of examining air for micro-organisms. It consists in aspirating a known volume of air through a glass tube containing two sterile plugs of glass-wool alone, or of glass-wool with fine glass-powder, etc., the first plug being more pervious than the

second. These plugs are then transferred to sterilized liquid gelatine peptone, and thoroughly agitated with it, and then the gelatine is congealed, so as to form an even film over the inner surface of the flask. The number of colonies which develop are then counted. The great advantage of this plan is its simplicity and accuracy.—*Br. Med. Jour.*, Jan. 15, 1887.

Robson (M.) on a Method of Treating Thyroid Cysts.—He advocates antiseptic incision and stitching the edge of the cyst to the skin, draining for a short time under an antiseptic dressing, and then packing with zinc lotion and lint. He read notes of two cases thus treated, the first in a girl, æt. twenty-two, who had a cyst the size of a Tangerine orange over the trachea, which occasionally produced dyspnœa; the second in a girl, æt. twenty-four, in whom the right lobe of the thyroid was forming one large cyst. In both the above treatment was perfectly successful, and produced no constitutional or local disturbance. When seen some time afterwards there was very little trace of scar, and no tumor in either case. He quotes from several standard surgical works to prove that the usual operations for thyroid cysts, such as injection, seton, etc., are either dangerous or unsatisfactory, and thought that the advantages of this method were its simplicity, safety, and certainty.—*Med. Press*, Jan. 19, 1887.

Stomach Digestion.—Opportunities for studying gastric digestion through fistulous openings into the stomach are, thanks to modern surgery, more frequent than formerly. This is important, as the physiology of digestion, as understood at the present day, requires more than the classical instance of Alexis St. Martin to place it on a sound experimental basis. Such a case with experiments *ad hoc* is recorded in a *revue scientifique* by von Herzen, of Lausanne. The subject was a man, æt. twenty-eight, on whom gastrotomy had been performed for occlusion of the œsophagus. The observations made were as follows: Bile always appears in the stomach during digestion, but generally only in the later stages. The amount of HCl amounts to 1.8 to 1.9 grm. pro litre; it increases during digestion and reaches its maximum in the third hour. Sodium chloride appears rather to diminish the amount of acid. When the stomach was empty in the morning, but little pepsin was found, and a large

amount of propepsin ; peptogen accelerated digestion. In the first hour, of a quantity of albumen introduced, 2 per cent. was digested without peptogen, 12 per cent. with it. In the second hour, 23 per cent. was digested without, 45 per cent. with, peptogen. In the third hour, 51 per cent. without, 76 per cent. with, peptogen. These results agree with those obtained by Schiff. Chloral, quinine sulphate, and above, all potassic iodide, retard digestion. The author would forbid red wine in disturbances of digestion, but would recommend bouillon and dextrine ; blood fibrine is also indicated in many cases.—*Med. Press*, Jan. 12, 1887.

The Flaxseed Fallacy.—If we were to ask every man and woman in almost any community, what is the best way to get any foreign substance out of the eye, probably fully one half of those questioned would say, "put a flaxseed into the eye—it 's a sure cure!" Every few days some one who has followed this advice comes to me for relief. Only a day or two ago a young man, with an eye full of flaxseed, came to me, stating that the seed had been in the organ all night, and that he could not sleep, because all night long *he could feel the seed chasing the foreign substance around and around under the lid*, but for some strange reason the substance "could not be forced out!" I have never seen any account of the origin of this superstition—for it is nothing more—but it is probably very ancient ; but unlike most ancient superstitions of this sort, it has absolutely no basis in fact. Any one who has a foreign substance in the eye and sends a flaxseed to "chase it out," simply adds fuel to the flame. It is fortunate that the seeds are smooth and comparatively unirritating, as otherwise the fallacy would be a more serious one. Another and similar superstition is that foreign matters may be chased out by a "stone from a crab's eye"—which is nothing more nor less than the crystalline lens of the eye of the crustacean, hardened by boiling. In their eagerness to do something in emergencies, the great mass of people rarely use common-sense—if they did, they would know that when one is not absolutely certain what to do, the best plan is to do nothing.—A. D. Williams in *St. Louis Med. and Surg. Four.*, Feb., 1887.

Treatment of Blennorrhagia.—According to the *Undo Medica* of October, 1886, Dr. Awssitidjiski records forty cases

of blennorrhagia treated in the following manner :

During four or five days he prescribes for his patients a potion containing five grams of salicylate of soda in one hundred and eighty of the infusion of linseed. In case that the sensation of ardor urinæ disappears, he orders injections of boric acid in two-per-cent solution to the number of from four to six a day for four days, ending finally with an injection of bichloride, 1 to 6,000, until the cure is complete.—*Four. Cut. and Genito-Urinary Disease*, Feb., 1887.

Stricture in the Urethra in Women.

—At a recent meeting of the Obstetrical Society of London, the proceedings of which we find reported in the *Lancet*, Dr. Herman mentioned six cases of urethral stricture in women under his own care, and gave the conclusions at which he had arrived from the study of these cases and twenty-three others that he had found recorded. While gonorrhœa, he said, was the ordinary cause of stricture in either sex, young persons alone being considered, aged men suffered chiefly from stricture of prostatic origin, and old women were found to be affected with stricture due to general fibrous thickening and induration of the urethra, the origin of which, he suggested, might reside in the urethro-vaginal cellular tissue, which was the homologue of the prostate. As to treatment, he had found rapid dilatation preferable to any other method.—*N. Y. Med. Four.*, Feb. 5, 1887.

Intestinal Displacement a Cause of Dyspepsia.—M. Glénard, a Vichy physician, believing that displacements of the intestine, or "enteroptoses," are a good deal more frequent than is generally supposed, and that they are, indeed, a common cause of dyspepsia, has been in the habit of examining the dyspeptic and neurotic patients who consult him by making them stand up, and then going behind them and pressing on the abdominal wall when in a relaxed condition. If this produces a distinct alleviation of the discomfort he considers that enteroptosis is present, and orders a binder, which in these cases gives great relief, only lasting, however, while it is actually worn. A discussion on this subject has just taken place at a meeting of a Paris Medical Society, but M. Glénard did not find many of his colleagues prepared to accept his views.—*Lancet*, Jan. 15, 1887.

PUBLISHERS' NOTES.

Horsford's Acid Phosphate.—Dr. H. P. Atherton, Great Barrington, Mass., says: "I have been using and prescribing your Acid Phosphate for a number of years. The results have been so satisfactory as to justify me in giving it my unqualified endorsement. I have found it a refreshing and exhilarating beverage during summer months. In a case of reformed inebriety I have observed its restorative effect in toning up the system and correcting the nervous derangement of the subject."

"Colden's Liquid Beef."—I have used "Colden's Liquid Beef Tonic" in my practice, and have been much gratified with the result. As a tonic in all cases of debility and weakness, "anæmia," "chlorosis," etc., etc., it *can not be surpassed*.

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Cod-Liver Oil Tonic.—In prescribing cod-liver oil, if you order Scott's Emulsion you will give your patient not only a pure oil but a combination holding the hypophosphites of lime and soda in intimate mixture.

Operating-Chair.—The conveniences of having an adjustable chair in one's office, for purposes to which the Klein chair, made in Chicago, is adapted, will be appreciated if Mr. Klein's circular be read.

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THE ELECTRO-MEDICAL BATTERY CO.,

Gentlemen:—I received the Battery all right, it worked at once, am very much pleased with it. If it needed a name I would call it "the busy bee." Thanks for your promptness. Respectfully,

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Decatur, Mich., March 4, 1884.

Ricord Capsules.—Send to E. H. Truex, 298 Pearl St., New York, for circulars pertaining to these capsules.

Lactated Food.—

ST. LOUIS, MO., October 9, 1885.

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Gentlemen:—I have prescribed Wells & Richardson Co.'s Lactated Food in a num-

ber of cases in which infants were suffering with inanition, marasmus, etc., when other preparations had failed, and the success obtained thus far has led me to believe it superior in most cases to other artificial foods.

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Gentlemen:—During the past year I have used Murdock's Food a good deal, and it has given me in every case thus far most excellent results. For anæmia, and in one case of pernicious anæmia, the results following its use were remarkably good. For certain forms of gastric irritability and feeble digestion I invariably recommend it. It has proved especially valuable in those cases of general debility in which tonics and iron prove useless. In short, I think highly of "Murdock" in all those cases in which the nutritive function is radically impaired.

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THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

VOL. IV., No. 3.

March, 1887.

WHOLE NO. 39.

LEADING ARTICLES.

Surgical Tuberculosis.—In a recent article¹ on tuberculosis of bone Dr. Roswell Park calls attention to the fact that British and American surgeons are far behind those of Germany and France in the study of tuberculous affections, and that almost nothing is to be found in the textbooks in the English language on this subject. In the journals, however, many valuable articles have appeared.²

In his own private practice, which is almost exclusively a consulting and operating one, Park estimates that about twenty-five per cent. of the cases seen are tuberculous surgical affections. In most of these cases he has confirmed the diagnosis by demonstrating the presence of the tubercle bacillus. Of these cases the majority are osseous lesions, including among them all forms of tumor albus, morbus coxæ, chronic caries, and necrosis of non-syphilitic origin, etc., formerly known as manifestations of a "scrofulous" diathesis.

Duplay³ says that up to the time of the discovery of the tubercle bacillus by Koch in 1883, tuberculous diseases were recognized by the anatomical structure of the tubercle, which was well known to be made up of a zone of embryonal cells containing in its centre a giant cell surrounded by a number of epithelioid cells. It was in this tubercle that Koch discovered the bacillus which he cultivated and then employed to successfully produce tuberculosis in animals.

By the injection of irritating or inert substances Martin produced a structure, non-infective, but histologically the same as that of tubercle, containing, however, no bacilli. From this it would seem that

the bacilli act only as irritants in producing tubercles.

According to Koch the micro-organisms of tuberculosis are present in the atmosphere in the form of spores, which, on entering the body, are transformed into bacteria.

The microbe may gain access to the human body by accidental inoculation or auto-inoculation during an operation to remove a tubercular lesion, by inhalation, by ingestion and absorption through the digestive tract (Chauveau), or by absorption through the genital tract (Fernet⁴).

When the bacillus has entered the tissues it may develop *in situ* or, more commonly, it is carried through the lymphatic or blood-vessels to some point—the point of least resistance—where it develops and multiplies.

This place of deposit seems always to have been prepared by a traumatism, as the experiments of Schüller demonstrate most positively.

He "made a number of animals inhale tuberculous sputum. Keeping some of them uninjured for purposes of control, he injured the joints of others; in every case a typical tumor albus followed each injury, while the uninjured suffered no such trouble. In yet other healthy dogs, who had inhaled no such infectious material, similar injuries caused only transitory symptoms, which had about them nothing of the tuberculous character. These investigations of Schüller were too carefully and numerous made to permit of doubt, and established the fact which now only needs universal recognition."⁵

In diseased tissues, which have been called tubercular on anatomical grounds, the characteristic tubercle bacillus can almost always, if not always, with proper

¹ *The Med. Press of West. New York*, Jan., 1887.

² See "On Surgical Tuberculosis," R. J. Hall, M.D. *N. Y. Med. Jour.*, Jan. 17, 1885.

³ *Archiv. Gén de Méd.*, Jan., 1887.

⁴ *La France Médicale*, Dec. 4 and 7, 1886.

⁵ Editorial, *Med. Press of West. New York*.

care, be found. "Practically, therefore, the simple microscopic examination of the tissue affords a perfectly reliable and simple means of diagnosis."¹ The preparation of material to be examined for bacilli requires much more skill and attention than to prepare it for ordinary histological examination to determine its structure, a point of much value to those whose time is limited.

Tscherning² reports a case showing inoculation through a wound. A strong, healthy servant girl, twenty-four years of age, cut her hand with a fragment of a spittoon, containing the expectoration of her master, who was ill with tuberculosis. A nodule developed near the wound, which was removed by operation and found to contain tubercle; later the axillary glands became involved, and on removal showed the presence of bacilli also.

Kraske³ has reported two cases which have been discussed in several journals, and are probably really cases of tubercular infection of wounds. One case was that of a boy, showing no evidence of tuberculosis, who entered the hospital and was operated on for necrosis following acute simple osteomyelitis. At the time of the operation there were no indications of tuberculous infection about the wound, and he was sent home three weeks later with a small, healthy granulating wound. At home he occupied a room which was also occupied by his sister, who was dying of phthisis, and here his wound was dressed by his mother, who also cared for the girl. Seven months after leaving the hospital he returned with sinuses about the original wound, which were lined with tuberculous material containing bacilli.⁴

The following case seems to be an undoubted case of infection through the respiratory tract.⁵ A healthy young officer, whose family history was free from tuberculous taint, returning to England from New Zealand with his wife, who was suffering from phthisis, and had large cavities in the lungs, occupied with her for four months a small, poorly ventilated cabin. The wife died soon after landing, and the husband then manifested symptoms of the disease.

In *L'Union Méd.*, of November 25th, is

¹ Hall, *N. Y. Med. Jour.*, Feb. 21, 1885.

² *London Med. Record*, Aug. 16, 1886.

³ *Centralblatt. f. Chir.*, Nov. 21, 1885.

⁴ See *N. Y. Med. Jour.*, Dec. 11, 1886, for cases of tubercular infection in wounds of circumcised

the following case of infection through the digestive tract. A young soldier returned to his home in a small hamlet, in the midst of a large forest, where tuberculosis in any form was unknown.

Soon after, he died of phthisis. His wife became tuberculous, and had a child which was also tuberculous. Another woman in the same hamlet (which consisted of but ten families) in turn presented classical symptoms of pulmonary phthisis.

She had had very little intercourse with the first family, but in the space of four months had eaten eleven chickens killed by them, and had not cooked the meat very thoroughly. Another fowl of the same brood died, and on examination, tuberculous lesions of the intestines were found, and the tubercle bacilli.

The fowls had become infected by eating sputa charged with bacilli, the report says.

Duplay describes two clinical forms of tuberculous lesions: one, the acute, characterized by the appearance of a number of symptoms like those of an acute inflammatory affection. The other, and the more common, comes on insidiously, and develops slowly, producing very little reaction. The acute form is rare, and has been observed in tuberculosis of the testicle, lymphatic ganglia, and serous articulations. In the acute cases, local pain, heat, and swelling mark the onset of the disease. An abscess is soon formed, the contents of which show caseous degeneration. From this time on these cases resemble the chronic form.

In the chronic cases, if a part accessible to palpation is involved, a hard, elastic nodule is found. In other localities, as the synovial membrane of a joint, pain and the difficulty of using the part attract attention. In these cases, too, an abscess slowly forms and discharges through an opening in the skin or mucous membrane, where an ulcer forms, or the mouth of a sinus is left.

As to the treatment, we will only say that some cases, especially in the young, recover spontaneously. If operations are done, they must be radical ones thoroughly carried out.

Park⁶ speaks very highly of a therapeutic measure known as *Ignipuncture*, which

children, from penis being sucked to prevent hemorrhage.

⁵ Dr. H. Bennett, *Brit. Med. Jour.*, Oct. 11, 1884; in *London Med. Rec.*, Aug. 16, 1886.

⁶ *Op. cit.*

consists in passing the platinum wires of a thermo-cautery through the soft parts, with or without a previous incision, down to the bone. It is indicated in chronic osteitis, where fluctuation and sinuses, or other indications of breaking down do not call for the curette or chisel. He has never known it to fail to relieve nocturnal osteocopia or starting pains, so often present in tuberculous affections of bones.

G. B. PHELPS, M.D.

Nasal and Naso-Pharyngeal Reflex Neuroses.—A brief abstract can hardly do justice to the very sensible and conservative lecture by Dr. P. McBride, in the *Brit. Med. Journal*, Jan. 29, 1887. To Voltolini is accorded the credit of having first observed the occasional dependence of bronchial asthma upon the presence of small nasal polypi. The fact has been confirmed by many others. Kohlrausch was the first to draw attention to the fact that the mucosa of the inferior turbinated body covers erectile tissue somewhat similar in structure to the corpus cavernosum of the penis. Under certain conditions this tissue tends to be more or less constantly in a state of erection, and may then excite such neuroses as asthma, nightmare, cough, megrim, supra-orbital neuralgia, redness and swelling of the nose and adjacent parts of the face, vertigo, and epilepsy. The extravagant statements of Hack, who first elaborated the theory of nasal reflexes, give the impression that nearly every neurotic ailment is amenable to cure by destruction of the mucous covering of the turbinated bone and of the subjacent erectile tissue. This observer even goes so far as to propose treating rheumatic inflammation of joints by destruction of the nasal erectile tissue. The area of reflex neuroses has been extended to include, not only the anterior extremity of the inferior turbinated body, but also its middle portion, as well as the middle turbinated body, which latter region also has been proved by Zuckerkandl to contain erectile tissue. The conclusions of Hack have been in part verified by Sommerbrodt, who, however, is not disposed to agree with Mackenzie, of Baltimore, in his assertion that nasal cough is a very common phenomenon. The last-named author believes that the posterior extremity of the inferior turbinated body, as well as the adjacent surface of the nasal septum, form a part of the sensitive area. Fraenkel, Schäfer, Baratoux, Hering, and

others have shown, on the other hand, that these neuroses may be due, not only to erection of the inferior turbinated body, but also to various hyperplastic conditions of the nose. Again, many good observers, with large amount of clinical material at command, among them Felix Semon, have decidedly failed to meet with the remarkable success in treatment reported by Hack and Sommerbrodt. Tornwauldt, too, who has made an elaborate study of diseases of the pharyngeal bursa, has had an experience with the treatment of diseases of that body which robs the erectile tissue of the nose of a monopoly in the causation of asthma, while cases have been recorded in which the removal of hypertrophied tonsils, or naso-pharyngeal tumors, has cured inveterate asthma. The author disputes the conclusions of Mackenzie, because cough is so rarely produced by the introduction of the Eustachian catheter, and yet he believes that nasal cough is not so very uncommon; in many cases, no doubt, being caused by secretion falling upon the inter-arytenoid fold from the posterior nares. After calling attention to the surprising difference in severity of reflex symptoms dependent upon the condition known as granular pharyngitis, the author refers to the question of the treatment of the morbid changes in the nasal mucosa, which seem, in certain cases, to give rise to the various neuroses. The galvano-cautery is the popular agent now in use. Its methods of action may be various: it may destroy terminal nerve filaments, and so prevent conduction of impressions; it may destroy, too, erectile tissue which has been provocative of hay-fever, rose cold, or nervous coryza, or it may act as a simple counter-irritant; finally, its effect may be more marked, for the reason that in the nose a sensory area in more direct communication with a nerve-centre is stimulated. The use of cocaine is said to be of diagnostic value in these cases of nasal reflex; menthol is preferred by Rosenberg. In view of the extraordinary differences of opinion regarding these reflex nasal phenomena, it seems reasonable to conclude that there has been a good deal of exaggeration and superficial observation in connection with the subject, yet it must be admitted that in a certain proportion of cases the cure of morbid conditions in the nose has been followed by relief of remote symptoms. At the same time, similar

symptoms have been made to disappear by strong stimuli applied to other parts, as in the experience of Schreiber; again, these symptoms have been cured by cauterizing perfectly healthy nasal mucous membrane. At the last International Medical Congress, Chiari reported a case of asthma, associated with aortic aneurism, which was relieved by cauterizing the inferior turbinated body. The discussion on the subject showed that the majority of observers do not accept Hack's views as to the importance of the erectile tissue in nasal neuroses. A recent critical review of the question by Boecker, discusses the relation between asthma and nasal disease. This observer admits the occasional connection, but thinks that asthma cannot generally be cured by attacking the turbinated bodies.

McBride summarizes his own views as follows:

1. That nervous phenomena manifestly associated with the nose, and producing what I may call the normal nasal reflexes, are frequently due to pathological changes of the nose,—for example, hay-fever, and other forms of nervous coryza, sneezing, and, perhaps, cough.

2. That other neuroses, such as asthma, megrim, etc., may occasionally owe their origin to nasal or pharyngeal disease.

3. That all neuroses belonging to the second class, cured or relieved by treatment of the nose or pharynx, need not necessarily be due to morbid conditions of these parts, because we may assume that the application of the actual cautery to the naso-pharyngeal mucosa is not less, and may be more, effective than cauterization of other parts which have been known to cure such neuroses.

4. That we have at present no means of knowing in any given case whether asthma, megrim, etc., can be cured by treatment of the nose.

5. That Hack's first work was calculated to raise expectations which are likely to remain unfulfilled.

6. That the weakness of voice in some cases of granular pharyngitis where the larynx is intact, may be a purely reflex phenomenon, and that in certain cases the application of electricity to the larynx is indicated, rather than destruction of the granulations. (*Brit. Med. Jour.*, Jan. 29, 1887.)

Quite recently a special study of these reflex phenomena has been made by Licht-

witz, who included in his researches, not only the mucous membrane of the nasal fossæ, but also that of the larynx and pharynx, of the gums, the conjunctiva, and the external auditory meatus. Spasmodic or lethargic attacks are known to be excited in certain hysterical patients by pressure upon some special region of the surface of the body. These "hysterogenic zones" have been investigated by R. Gaube (*Thèse de Bordeaux*, 1882): the "lethargogenic zones" have been particularly described by Blanc-Fonteuille. Now Lichtwitz publishes an elaborate article upon "hysterogenic zones observed in the mucous membrane of the upper air passages and of the organs of sense," and narrates six cases, with many interesting details. All the cases presented nasal fossæ with spasmogenic zones, except one, a woman, twenty-nine years old, in whom hypnotic attacks followed even the introduction of the nasal speculum. The effect of cocaine was variable, in some cases abolishing the zones, in others failing in part or completely, perhaps in consequence of the difficulty of applying the anæsthetic without provoking an attack. The author considers a recognition of these zones of real practical value, especially during the performance of minor operations upon hysterical subjects.—Abstracted from a reprint from the *Rev. Mens. de Laryngol.*, etc., No. 12, 1886, kindly presented by the author).

L. de Gennaro (*Rev. Mens. de Laryngol.*, etc., Jan., 1887) divides the theories formulated upon the pathogeny of reflex neuroses into two classes: the first includes those admitting the existence of a *very limited* reflex zone in the nose (Hack, Barataux, Brebion, Hering); the second includes those recognizing that sensitive reflex areas may be formed in any part of the nasal mucosa (William, Lieblinski, Rossbach, Kratschnan, Heymann). He gives the notes of two cases of reflex nasal neurosis, and after analyzing the different theories, concludes that neither the circumscribed nor the diffuse theory is sufficient to explain all the phenomena associated with nasal affections. He admits an hysterical or neurotic condition, which in the presence of a nasal lesion may develop a reflex neurosis. C. H. KNIGHT, M.D.

Browne (E. A.) on Prolonged Irrigation in Lachrymal Suppuration.—It is acknowledged by all practical men who care rather to express the exact truth

than to magnify their personal success, that the treatment of the lachrymal passages leaves something to be desired. In spite of a considerable amount of success attained by modern methods, in every large clinic there will be found a residuum of unsatisfactory cases. Indeed, some authors have gone so far as to deprecate much interference, on the ground that after all treatment, the last stage of epiphoral man is worse than the first. As the passage is easily reached, and its anatomical configuration simple, there seems no obvious reason why difficulties should be insuperable. The recognition of even one cause of failure may result in improvement. Such a one consists in the continuance of a purulent or muco-purulent discharge, indicating a thickened and swollen mucous membrane that reduces the calibre of the duct, and by its tenacity impedes the descent of the tears through the narrowed channel.

Whatever may be the cause of the stricture, suppurative as in acute dacryocystitis, or chronic discharge as in blennorrhœa or mucocele, is certainly due to the retention of pyogenic germs within the cavity. No place can be conceived more favorable for the growth of germs than the warm moist cavity of an obstructed lachrymal sac. The extreme difficulty of dislodging these favorably placed germs, and of rendering the surface of the mucous membrane thoroughly aseptic, is one main factor of the persistent character of lachrymal sup-puration.

Impressed by the value of prolonged irrigation in gonorrhœal ophthalmia,¹ I have applied the same method to suppurating sacs. It is not the mere application of an antiseptic that is curative; it is its prolonged application. Every germ must be washed away and the cleansed surface so soaked with the antiseptic as to form an unfavorable or impossible soil for germination. This holds good equally in acute and chronic cases. The principle once admitted, there is no difficulty in its application. Allowing for small modifications that may be indicated in individual cases, the procedure is somewhat as follows:

Acute dacryocystitis.—The canaliculus is

slit, and a knife passed down the duct, incising the membrane as much as may seem needful. The largest-sized bulbous-pointed probe that will glide easily down, is used to ascertain that the passage is free. A canula probe, or small-sized gum-elastic urethral catheter, is now passed, and connected by means of an india-rubber tube six or eight feet long, with an elevated reservoir holding a pint or more of fluid. The fluid is allowed to run when the orifice of the canula is in the nares, and the tube is almost imperceptibly raised by the surgeon. With a little care and a great deal of patience, every portion of the duct may be effectually irrigated.

Chronic blennorrhœa.—After dilating the stricture, if necessary, thick tenacious mucus is dislodged by a preliminary irrigation with an alkaline solution. If this is not done the antiseptic may fail to reach the mucous membrane.

The fluids employed have been: (1) A solution of trichlorphenol (magnesium-salt) 0.5 per cent.; (2) a solution of biniodide of mercury prepared according to M. Panas' formula.

It is confessedly difficult to estimate the value of a therapeutical procedure. The only test is that the same remedy should give the same result in the same class of cases in different hands. The necessary encouragement for the employment of a remedy is afforded when the scientific indications and practical results are in harmony. In the present instance, if we admit the potency of germ growth in maintaining a persistent discharge, and if we admit the necessity (as we must) of prolonged exposure to a germicide to produce sterilization of an invaded tract, we shall have the necessary indications. The impression produced on my own mind, by comparing a considerable number of cases treated in various ways, is that the indications can be met by this method: the limitation of usefulness, be it always understood, coinciding with the existence of a purulent or of a quasi-purulent discharge, as the difficulty to be overcome.—*Practitioner*, Jan., 1887.

Neve (A.) on a Case of Incision and Free Drainage of the Lung for Phthisical Cavities.—It is only within quite recent years that notices of attempts to drain purulent collections in the lung itself have appeared in the journals. As far as I can make out, the cases as yet are

¹ At the meeting of the British Medical Association at Belfast, I showed a convenient instrument for irrigating the upper conjunctival *cul de sac* in gonorrhœal ophthalmia, and drew attention to a method of treatment which I still consider highly valuable.

confined to one or two for abscess, several for gangrene, and more recently one or two for bronchiectasis. But that the operation has not taken a recognized position is shown by the fact that in Quain's "Dictionary of Medicine" it is only mentioned in connection with gangrene, and then but casually as an alternative of tapping. The case which I have to record is as follows :

A young man, haggard and wasted to a degree, was admitted April 10, 1886. For a year he had been suffering from violent cough and profuse expectoration. His appearance was that of a man in the last stage of phthisis. His fingers were much clubbed. The expectoration amounted to a pint and a half or two pints in the twenty-four hours. It was tough, and in large flocculent, purulent masses. Microscopic examination showed a very considerable proportion of pus cells, with elastic fibres, etc., and swarming with bacilli. Examination of the chest revealed the presence of cavities in the upper and anterior part of the right lung, while the right base and most part of the left lung were fairly healthy. The left apex appeared condensed, with possibly commencing softening. For nearly three weeks the patient was treated with cod-liver oil, tonics, eucalyptus and creasote spray, and counter-irritation. During this time there was no improvement, and the patient (a troublesome one) was clamorous for something to be done. Accordingly, on April 29th, having administered chloroform, I made an incision two inches long close to the right nipple, through which a corresponding portion of the fourth rib was resected, with the periosteum attached. The pleural surface was, as I expected, firmly adherent. I then forced my finger inwards and upwards in the direction of the cavities. There was no such large cavity close to the wound as I had hoped to find ; but upwards it entered two small cavities. The tissues were hard, but friable. I did not attempt to open the cavities on the axillary side, deeming that they would drain by the bronchi into the wound. A large-sized drainage-tube, six inches long, was passed into the lung, and the wound closed by a pad of gauze and a sawdust bag. Hemorrhage was quite inconsiderable, and the air whistling through the wound gave promise of good drainage. Within two days the expectoration by the mouth was diminished to three or four ounces, and was no longer accompanied

by the distressing cough which the man had complained of. There was, however, much pain about the wound. It was daily washed out with corrosive sublimate solution, and pure oil of eucalyptus was poured into the tube. At first this gave rise to cough, but toleration was established. Inhalations of creasote and eucalyptus were continuously maintained by keeping the pad on the wound moist with them. The discharge from the tube was chiefly mucopurulent ; at first bloody, later thick and tenacious, but progressively less so. About the fourth week the patient began again to complain of the drainage-tube (which he had himself removed several times during the first two days) ; a little blood also appeared on the dressings ; so, fearing ulceration into the vessels of the lung, I removed it altogether. In the early part of June the sputum continued healthier, and he went home. On the 24th he returned. The improvement was then striking, especially in the local signs. The chest around and above the wound was considerably contracted and sucked in. The sinus was freely open, and upon coughing some mucus was expelled from it. The healthy area of the lung seemed increased. The apex of the left lung, however, showed more signs of breaking down. He remained under observation in hospital for two days, and was photographed. The expectoration was about ten ounces in twenty-four hours, but was chiefly clear and watery, with a few nummular masses similar to those of which it formerly entirely consisted. His cough troubled him only in the morning ; he slept and ate well, almost ravenously, and gained strength, though but little flesh. He was then sent to a mountain sanatorium eight thousand five hundred feet above the sea. Up to this point the improvement effected was entirely by means of the operation. Since that time I have not seen the patient, but occasionally receive reports from his friends. After September he became weaker. He is said to wander over the country, is seldom at home, and does not work. There still remains a small opening in the chest.

Remarks.—In resorting to pulmonotomy for a case of advanced phthisis, I was performing an irregular proceeding, though it was most fully justified by the amount of the expectoration, by the limitation of gross lesions to one lung, and to a not very ex-

tensive area therein, and, therefore, by the possibility of effective drainage. An operation, moreover, offered the means of directly medicating the affected parts, and of delaying or arresting the advance of disease in the other lung, which would have rapidly determined a fatal issue. For these reasons I did not hesitate to avail myself of the willingness of the patient to undergo an operation which he was given to understand would alleviate his distress. The result was as satisfactory as I had anticipated. The cavities which were opened, and also those higher up in the apex, ceased to secrete such a large amount of sputum, and apparently cicatrized. In this they were assisted not only by the drainage and topical medication, but by the removal of a considerable portion of rib, with the consequent possibility of retraction of the thoracic wall. The slight amount of respiratory movement of the upper part of the chest and lung is probably the chief cause of the special liability of the apex to the formation of tubercle and its resulting cavities; but even this slight movement is probably unfavorable to the healing of such cavities when the pleural surfaces are adherent. I therefore think that in many cases of phthisis with apical vomicæ it might be beneficial to remove portions of the upper ribs, as in Estlander's operation for empyema. If a similar case presents itself, but with less abundant sputum, I should be disposed to try the resection of portions of the second and third ribs, with intra-pulmonary injections. As the preliminary to all operative methods, the usual antiseptic inhalations and other remedies should be fully tried. Having decided to operate, the aspirator should be used to confirm the diagnosis as to the position of the cavity. The first risk met with in operating is that arising from non-adhesion of the pleura. Circumstances may point towards adhesions, but the diagnosis must always be attended by uncertainty. Puncture and drainage of a cavity, where the pleural cavity is not shut off from the purulent secretion, would lead almost necessarily to a pyogenic pleuritis. If after resection of the rib the pleura is found non-adherent, it would probably be best to unite the lung by catgut stitches to the thoracic wall, and postpone incision into the lung for a few days, when the exuded lymph will occlude the pleural cavity; this might not be practicable on account of

collapse of the lung, but at least it might be attempted by seizing the lung with a sharp hook, and effecting the suture promptly. In making the incision it is not necessary to use a sharp instrument. The friability of the lung often permits of the finger being used, in which case dangers are avoided and information procured which no other instrument could give. In my case bleeding was insignificant, and most surgeons have found that if it occurs it is easily arrested. Drainage takes place less by gravitation than by the expiratory efforts; but position can do much towards helping these. Similarly, position, aided by inspiratory efforts, will effectually distribute antiseptic applications, such as iodoform dust, eucalyptus oil, etc., to sub-jacent parts of the lung, and their effect may be kept up by the use of volatile antiseptics in the dressing used. As in all my surgical cases for the last four years, I use large pads of cedar sawdust, to which I add creasote, etc.; these act as respirators, filtering and warming the air. I may add that the operation cannot be taxed with failure because a permanent cure is scarcely to be achieved, inasmuch as legitimate operative interference is necessarily delayed until the disease has made great headway, and the local symptoms, grave as they may be, are but the manifestations of a graver constitutional disease.—*Lancet*, Feb. 5, 1887.

THERAPEUTICS.

A New Hypnotic — Methylal. — Methylal is a colorless, extremely volatile liquid derived from methylic alcohol. M. Personali has found that when given hypodermically, by the mouth, or by inhalation, it produces sleep and suspends reflex action. During sleep respiratory movements are slower but of greater amplitude, while the galvanic excitability of muscles or nerves is unchanged. The pulse is made more rapid; the arterial tension and bodily temperature lowered.

It is very rapidly eliminated, but it is not yet known how. It appears to be somewhat antagonistic to strychnia, as is paraldehyde.

It is used both internally and externally, the dose by the mouth or rectum, according to M. Nicot, being gr. xv.—*L'Union Médicale*, Jan. 18th.

The Results of Pasteur's Treatment of Rabies up to December 31, 1886.—Among all patients, French and foreigners, of those bitten by animals, proven by experiment or asserted by veterinarians to have been rabid, there were 2,164 cases. Of these there died 29 cases; giving a mortality of 1.34 %.

Of persons bitten by animals suspected to be rabid there were 518 cases. Of these there died 2 cases; giving a mortality of 0.38 %.

Of all persons bitten and treated there were 2,682 cases. Of these there died 31 cases; giving a total mortality of .15 %.

Of persons bitten about the head and face and treated there were 214 cases. Of these there died 10 cases; giving a mortality of 4.66 %.

In these cases the animal was known to be rabid in 186 cases. Of these there died 9 cases; giving a mortality of 4.83 %.

The animal was not proved to be rabid in 28 cases. Of these there died 1 case; giving a mortality of 3.57 %.

Of cases where the animals were known to be rabid, and where the wound was about the head or face, there were 186. Of these there were treated by the *simple method* 136 cases. Of these there died 10 cases; giving a mortality of 6.66 %. Treated by the heroic method there were 50 cases, none of which died.

Bitten by mad wolves there were 48 cases. Of these there died 7 cases; giving a mortality of 14 %.

Of the 31 fatal cases two did not apply for treatment until 35 days, one 34 days, and one a month, after being bitten; one was seized with rabies on the sixth day, and one on the first day, after treatment.

Five of the cases treated died of diseases other than rabies.—*La Tribune Médicale*, Jan. 23, 1887.

Mackenzie (S.) on the Value of Indian Hemp in the Treatment of a Certain Type of Headache.—The headache to which I wish to draw attention is of a dull, continuous, or subcontinuous character, attended sometimes with paroxysmal exacerbations. What is especially characteristic of it is its constancy. Patients will tell you that they rise with it in the morning, are troubled with it all day, and carry it to bed with them at night. If by chance they awake in the night, they find their head is aching. The headache may in some cases become aggravated as

the day advances, but sometimes the opposite condition obtains, and the headache is worse at the early part of the day. The situation of the headache varies; it may be frontal, temporal, or occipital, or, more rarely, vertical. Usually, however, it is diffused. It is not as a rule attended with local soreness or tenderness. Nausea may be present, but is not constant; vomiting is usually absent. In some cases distinct exacerbations, sometimes of great severity, occur. As these subside, they give place to the dull, continuous headache that preceded their advent. As a rule, the ocular phenomena characteristic of migraine are absent, and the headaches are not usually hemicranial. Constipation is present in a certain number of cases, but removal of the constipation does not cure the headache. In some cases it is associated with disorders of digestion, but the same remark applies to these as to constipation.

Headaches of this type may last for weeks, months, or even years. They occur in persons of different ages, but are, perhaps, most common in the middle period of life, and in young adults. Several of my best-marked cases have been in medical students. Patients so suffering are usually able to pursue their usual avocations, except, perhaps, during paroxysmal exacerbations, especially when their work is of an active rather than of a sedentary and intellectual character. Thus medical students have been able to attend to their dressing and other duties at the hospital, but when they have attempted to read they have found it impossible; the headache prevented the full engagement of their attention.

As to the nature of these continuous or chronic headaches, I do not intend to offer a decided opinion, but I hope further experience will reveal it. All I can safely affirm is that they are not due to peripheral irritation or anæmia. They do not seem to be of the nature of megrim—at least in the majority of cases. I have thought they may be due to some dyscrasia or diathesis. In a few cases it has seemed a slight malarial taint might be present; in others gout or rheumatism appeared a possible cause. These, however, are conjectures only, unsupported by sufficient positive evidence to warrant definite conclusions.

For the relief of headaches of the class I have described, I have found Indian hemp of the greatest service. In the majority of

cases it cures the complaint. The one element of the headache which, in my experience, indicates the probable success of the remedy, is its continuous character.

The preparation of Indian hemp I always employ is the extract. I begin by giving one third or more (usually half a grain) night and morning, or occasionally three times a day. If at the end of a week some amelioration of the headache has been procured, I advise its continued use in the same doses; but if little or no improvement has taken place, I increase the dose to one grain at night and half a grain in the morning. If this is insufficient, I increase the dose so as to make it one grain night and morning; this failing, I increase it by half-grain doses, giving the maximum dose at night, until two grains at night and one and a half grains in the morning are reached. I have scarcely ever had occasion to exceed these doses. There are two points I wish to urge: 1. The gradually increasing dose. 2. Steady perseverance in its employment. The treatment must be as obstinate as the disease.

Given in these doses, usually no inconvenience is experienced by those taking *cannabis indica*; but a few patients have complained of a feeling of slight confusion or giddiness, not in any way so annoying as the condition for which it was administered.

The length of time over which treatment has to be continued varies in different cases; usually it extends over several weeks, but rebellious cases may require a treatment of two or three months. As the malady recedes, the dose should be reduced, and it is advisable to continue the administration of the remedy for a week or two after the headache has disappeared.

In the majority of cases the Indian hemp may be given alone, with compound glycer-rhiza powder, powdered valerian, or extract of gentian, as excipients. My largest experience has been gained in many years' out-patient practice, where, for therapeutic testing and teaching purposes, simplicity has been studied. It by no means follows, however, that because our patient has a headache, we are not to attempt to relieve his other sufferings. Thus, when constipation is present, as it is in a fair number of cases, some aperient may conveniently be combined with the hemp; aloes and myrrh pill, compound rhubarb pill, in small doses, may be added to the *cannabis indica*.

Where flatulence troubles the patient, compound assafoetida pill, carbolic acid, or quinine, separately or combined, may be given with the Indian hemp in a pill. I have, however, had the most striking results with the Indian hemp alone.—*Br. Med. Jour.*, Jan. 15, 1887.

Crothers (T. D.) on Cocaine Inebriety.—The following conclusions are sustained by the best evidence which has been presented so far.

The use of cocaine to excess in persons who have never used alcohol or other narcotic drugs before, is very rare. Among inebriates and drug maniacs, cocaine inebriety is no doubt increasing. Its peculiar dangerous effects on the body will prevent its general use as an intoxicant to any great extent. It acts more rapidly than opium, but its effects pass off more quickly. Its first effect is more exhilarant than alcohol, but it is uncertain and variable. This stimulant action develops mania, followed by narcotism and melancholia. When given in cases of melancholia in large doses, it changes the case to mania, then finally relapses, bringing back the case to melancholia again. As an intoxicant it is more dangerous than alcohol or opium. As a form of inebriety it is more difficult to treat, requiring a longer time to break up, because of the physical and psychical complications. It cannot be used as a substitute for any other narcotic, or as an antidote or remedy.—*Quar. Jour. of Inebriety*, Jan., 1887.

Odbert (F. N.) on a Chloral Habitué.—During the early summer of last year, a young man consulted me for spasmodic asthma of six months' duration, which had occasioned him much distress. He had run the gauntlet of remedies for relief, without much avail, and finally took to chloral for its palliative effects. Immediately upon taking twenty or thirty grains the spasm would relax. After the continuance of the remedy for two or three months an unusually severe attack of asthma developed at midnight, for which thirty grains of chloral were taken, but as it did not relieve him, in two hours he took thirty grains more. I was summoned at 12 M. the same day, and found the patient in a semi-comatose condition, with a feeble pulse of 120, respiration slow and irregular, pupils dilated, face pale. By making a strong impression on the patient he could be partially roused, and would talk coherently

for a few moments, and then would relapse again into profound sleep, announced by stertorous breathing.

The ordinary remedies were used to resuscitate the patient, but they made but a very feeble impression. For four days he slept continuously, and it was with great difficulty that he could attend to his business on the fifth day. The continued stupor suggested to me that he might have clandestinely taken the hypnotic, but the patient's surveillance was so strict, that it would have been impossible to have deceived his attendants. Since his recovery from the asthma, he has repeatedly assured me he did not take but the two thirty-grain doses mentioned, which caused the alarming symptoms. He said, whenever he was under the moderate effects of the drug, he at times was seized with an irresistible desire to take a lethal dose, a thing which never suggested itself when not stimulated by the medicine.

A striking idiosyncrasy I noticed in the patient while under the effects of chloral was the immediate recurrence of the attack of asthma upon the administration of any stimulant containing alcohol, and the paroxysm would continue until it was eliminated from the system.

Although he had taken the hypnotic nearly six months the usual symptoms of chronic chloralism, viz.: hyperæmia of the conjunctiva, dyspnoea, pain in the extremities, vesical irritation, etc., were absent.—*Peoria Med. Mo.*, Jan., 1887.

Iodoform and Silver.—A curious effect of iodoform and silver is reported by Dr. Poncet, who had his attention directed to it by a patient, to whom he had been applying iodoform dressing, telling him that all soups and other diet for which she used a silver spoon had a very disagreeable taste, and the spoon itself had a garlicky odor. Upon investigating the subject Dr. Poncet found that silver that has been in contact with iodoform, or which is even touched by the fingers after they have been in contact with iodoform, acquires a nauseous odor, resembling that of garlic, which becomes more perceptible upon rubbing the silver. A drop of saliva from a patient fully under the influence of iodoform is said to be sufficient to impart this odor to silver, or the mere exposure of iodoform and silver in the neighborhood of one another. The odor is not that of iodoform, but is thought to be due to a decom-

position product.—*Med. Press*, Jan. 19, 1887.

Dally (E. O.) on Rash Produced by Antipyrin.—Two cases have lately come under my notice, in which a rash closely resembling that seen in measles appeared in patients who were taking antipyrin. The rash observed differed from that of measles in the following points:—

1. It did not make its first appearance on the forehead, was most marked on the extremities, though also present on the trunk, and to a limited extent on the face.

2. It was not arranged in crescentic patches, and its color was rose-red.

3. There was an absence of general symptoms; for example, swelling of the face and eyelids, coryza, lachrymation, cough, etc.

4. Its duration was only from twenty-four to thirty hours, quickly subsiding after the drug was left off.—*Brit. Med. Jour.*, Jan. 15, 1887.

Duckworth (D.) on Chalk Ointment as an Application in Erysipelas.—It appears to be quite immaterial whether the *creta præparata* or the *calcii carbonas præcipitata* of the Pharmacopœia be employed. Although the latter is a crystalline powder, and the former amorphous, both, when pure, are for all practical (*i. e.* clinical) purposes impalpable. To secure suitable consistency, and to ensure full benefit, it is necessary to incorporate a large amount of chalk in the ointment. It is noteworthy that lard will blend with an extraordinary quantity of chalk, either by beating in a mortar, or by adding it gradually to the lard previously melted. It is possible to make a very dense ointment by blending two and a half ounces of chalk with one ounce of lard. This is too firm to apply to a painful erysipelatous part, and in cold weather it almost crumbles. And the best results as to quantities have been attained by mixing *equal proportions* of each, the lard being previously melted. Half a drachm of pure carbolic acid may be added to each ounce of the ointment. That prepared with *creta præparata* is of the color of putty. The other is pure white. Both are equally serviceable.

The earliest recommendation of a thick chalk ointment I can find is that of Mr. J. C. Spender, of Bath, who introduced it as an undoubtedly valuable preparation for intractable ulcers of the leg. In his book entitled "Observations on the Causes and

Treatment of Ulcerous Diseases of the Leg," published in London in 1835, he remarks that the best outward application is an ointment containing a very large quantity of prepared chalk. "The earthy matter," he states, "must be in a much greater proportion than enters into any ointment in the Pharmacopœia, consisting of about three pounds of chalk to two pounds of lard."

He advises that the lard be first melted and the chalk gradually added in order to secure more intimate blending than can be attained by simple admixture or trituration.

In a re-issue of this book by his son, Dr. J. Kent Spender, of Bath, in 1868, the same process is again recommended. The ointment is to be applied with the finger and smeared thickly over the erysipelatous part. A mask of plain lint or of boracic lint should be laid over this and properly secured.

Patients express themselves as feeling relieved by this, and prefer it to other applications which may have previously been used.¹ An ointment of this kind and consistency presents several advantages over the old method of dusting flour over the affected part, especially on the face, since, to be effectual, the dredger has to be constantly in use. The flour also gets within the eyelids, causing sometimes great irritation of the conjunctiva. I venture to commend, with some confidence, the local application of chalk ointment in erysipelas as being at once cleanly, unirritating, readily procurable and trustworthy, and at the same time cooling and soothing.

In severe cases it may be necessary to re-apply the ointment twice or oftener every twenty-four hours.² I think I may add that this preparation is now the favorite one in the erysipelas wards of St. Bartholomew's Hospital.—*Practitioner*, Jan., 1887.

Illingworth (C. R.) on Iron in the Treatment of Bronchitis.—To my mind there are physiological reasons for giving iron in all cases of bronchitis as soon as the sympathetic congestion of the digestive tract, indicated by the dry, hard tongue, is removed by diaphoretic treatment. As soon as the tongue is moist, I

prescribe five-minim doses of the perchloride of iron with glycerine every hour or two, according to the urgency of the case. When the complexion is dusky from abundant capillary secretion, with consequent imperfect aëration of the blood, I give this dose every hour to an adult, and drop doses to a child. The physiological reason I refer to is the absence of fibrin, or great decrease of the fibrin elements of the blood in asphyxia. These it is the province of iron to supply. And the benefit I have seen accrue from such treatment is most marked and rapid.

I find the same answer well in cases of pneumonia and broncho-pneumonia. There is abundant secretion, with deficient power of expectoration. The tongue is moist and flabby; skin dusky; heart's action weak and fluttering. In such cases steel every half-hour or hour in five-drop doses works a rapid change for the better.—*Provinc. Med. Jour.*, Feb. 1, 1887.

Effect of Iron on the Composition of Milk.—Dr. Mendes de Léon has made a number of researches and observations on the supposed effect of taking iron on the composition of the milk secreted. He finds that milk always contains a minute quantity of iron, which differs in different species of animals, cow's milk, for example, being richer in iron than human milk. He gave various preparations of iron to a healthy multipara and analyzed the milk, but was unable to detect any increase in the iron it contained, so that it would appear that iron given to the mother does not act on the child by passing into its system, but that it may act by improving the general condition of the mother, and thus causing her to secrete better milk.—*Brit. Med. Jour.*, Jan. 29, 1887.

Lewis (J. A.). Apocynum Cannabinum in Dropsy.—I have to report the history of a few cases of pleurisy with effusion treated with apocynum cannabinum. I prefer to give those cases that fell in my hands after the effusion was well marked.

CASE I.—J. C., aged 13, male, January 15, 1885. Was taken sick January 7th with initiatory chill, followed by high fever, cough, and rapid respiration; effusion well

¹ *Op. cit.*, p. 64.

² I once was called to see a case of erysipelas of the face in which white paint had been employed. It caused fearful suffering, was distinctly mischievous, and, worst of all, could not be removed.

³ I find in Dr. Druitt's "Surgeon's Vade Mecum" a formula for chalk ointment: $\mathcal{B}$ cretæ precipitatæ $\frac{3}{j}$., ol. olivæ 3 iij., adipis $\frac{3}{ss}$. M. For burns, excoriations with acrid discharge, etc. P. 776. edition of 1869.

marked; level of fluid at fourth rib. Treatment: fl. ext. apocynum cannabinum, $\frac{3}{i}$. Five drops every three hours.

January 19th.—Feels better; fluid disappearing; at level fifth rib.

January 29th.—Fluid entirely gone; appetite good; temperature and pulse normal: discharged.

CASE II.—*January 24, 1886.* George P., aged 18; barber; taken sick with pain, fever, and rapid respiration.

January 1.—Confined to bed two weeks; improved, and was able to walk out; had been treated for intercostal neuralgia. Physical examination revealed the fact that his left pleural cavity was entirely filled with fluid; was given fl. ext. apocynum cannabinum 20 drops every four hours; free catharsis took place after the fourth dose; drug diminished to 10 drops every four hours; rapid recovery took place, with complete expansion of lung and normal respiration February 15th.

CASE III.—*March 28, 1886.* John C., aged 14; waiter-boy on railroad. After violent exercise, February 10, 1886, was taken with chill, followed by fever, cough, slight pain in side. Nothing was done for him until he came to me, March 28th; right pleural cavity nearly filled with fluid. Treatment: fl. ext. apocynum cannabinum. Ten drops every four hours were given. Lived six miles from me, so did not see him again until June, when I met him by accident. His story was that he got well in a week, and went to work May 3, 1886.

CASE IV.—*Mrs P., aged 43.* History of latent pleurisy of four weeks' standing of left chest; complete flatness on percussion; heart to right of sternum; no vesicular murmur in lung. Change of position did not alter the physical signs. Advised aspiration, which she would not consent to until drugs had been tried. Treatment: fl. ext. apocynum cannabinum, gtt. xv., potassæ iodidi, gr. viii., per dose every four hours.

May 5th.—Feels a little better; treatment continued, and by May 18th all fluid had disappeared, and she has remained well since.

CASE V.—*Susie G., aged 23; shop-girl.* History of latent pleurisy; right chest filled with fluid to fourth rib; has been treated for intercostal neuralgia. Treatment: fl. ext. apocynum cannabinum, gtt. x. every four hours. Fluid rapidly disappeared, and she remained well until December, when I was called by Dr. Winslow to see

her at his office. She then had aphonia from ulceration of the vocal cords, which is undoubtedly laryngeal phthisis. There was no fluid in the chest. He has since lost track of her.

CASE VI.—*Harris B., aged 3, son of Dr. Beckwith, of Ithaca.* Taken sick July 10th; chills, fever, slight cough, and pain in abdomen. Was asked by the doctor to see him July 18th, when we found right chest nearly filled with fluid. Advised fl. ext. apocynum cannabinum, gtt. ii. every two hours, until free catharsis took place, then to diminish to 1 drop. The fluid entirely disappeared in fourteen days. He has since remained well.

CASE VII.—*Grace C., aged 4 years.* History of acute pleurisy, commencing November 10th; right chest filled with fluid. Treatment: fl. ext. apocynum cannabinum, gtt. iv. every four hours; complete recovery in fifteen days.—*Therapeutic Gaz., Jan., 1887.*

Da Costa (J. M.) on Cocaine as a Cardiac Stimulant.—A laborer, twenty-nine years of age, was admitted into the hospital on the 15th of last month, suffering with typhoid fever. During the progress of the case I was much struck with the weakness of the pulse and the whole condition of the patient. There was no congestion of the lungs, and no local lesions to account for this, but he was suffering from the secondary effects of the typhoid-fever poison upon the circulation.

I then placed him upon cocaine hydrochlorate, a quarter of a grain every two hours, and subsequently half a grain at the same interval, and reduced the whiskey to eight ounces a day. The improvement was striking; cocaine showed its power here as it had in similar cases I have seen elsewhere, and in the hospital two years ago. The patient, upon whom ordinary stimulants had very little effect, began to improve in the course of twelve hours after it was begun, and the cocaine was gradually reduced, and was stopped entirely last week.—*Medical Times, Feb. 5, 1887.*

Tirard (N.) on Hyoscine in Kidney Disease.—In the spring of 1884, the patient, a man aged fifty-eight, sent me a sample of his water to examine; I found it contained a considerable amount of albumen, and casts indicative of chronic kidney mischief. He consulted me again in the autumn of 1886, when he had slight œdema of the lower extremities, shortness of breath

on exertion, cough with slight mucous expectoration, and occasional asthmatic attacks at night. The urine was now found to be nearly solid with albumen, and hyaline, granular, and oily casts were present. The patient was much emaciated, his digestive power was impaired, and the heart's action was rapid and feeble. From this time, in spite of treatment, the symptoms gradually became more serious until November 23d, when he first complained of sleeplessness. Chloral hydrate, bromide of potassium, and cannabis indica proved unsatisfactory, and it was finally decided to employ hyoscine. The solution was prepared for me by Mr. Martindale, according to the formula of Dr. Mitchell Bruce.

B Hyoscinae hydriodatis . . . gr. j.
Aque destillatæ ℥. cc.

The conclusions I drew from my observations on this case are the following :

Hydriodate of hyoscine is a drug which can be used with perfect safety in cases of kidney disease where morphine is inadmissible. It is a drug which may give rest when other sedatives fail.

If used in two-minim doses subcutaneously, it may give more satisfaction to the patient than to the attendants, since the unconsciousness may be accompanied by angry and combative delirium ; should this occur, it will probably be sufficient to diminish the amount employed.

It is very rapid in its action, unconsciousness following in from ten to twenty minutes, and the after-effects are of a soothing character.

Even when delirium is present in a violent form, it is followed by quiet sleep, and the patient, being unconscious, is much more refreshed than by a night of short snatches of sleep produced by chloral or bromide, and the result is a marked improvement in both aspect and temper. And lastly, no irritation is produced around the site of injection.

I believe that hydriodate of hyoscine will probably take a firmly established position as a sedative in cases where morphine cannot be employed.—*Practitioner*, Feb., 1887.

Locquin on the Employment of Iodoform Injections in Tubercular Cystitis.—Iodoform being soluble in only such liquids as cannot be applied to the mucous membrane of the bladder, the author uses the following mixture :

Iodoform	one part.
Gum acacia	20 parts.
Water	300 parts.

The crystallized iodoform is slowly incorporated with the mucilage, and when shaken remains in suspension long enough to be injected into the bladder, where it there slowly deposits.

It is tolerated by the bladder ; under its influence the purulent deposit gradually ceases ; the tenesmus and frequent micturition is at once lessened and finally relieved, rendering the waking hours more endurable and the nights less sleepless.—*Gaz. des Hôp.*, Jan. 15, 1887.

Cazaux on Hot Water in Acute Prostatitis.—Enemata of water at 130°F., by means of an irrigator, three times a day for a week or less, and perineal hot applications suffice, according to the author, to cause resolution in the most violent cases of acute prostatitis.—*Thèse de Paris : Bul. Gén. de Therap.*, Jan. 30, 1887.

Millikin (B. L.) on Large Doses of Iodide of Potassium in a Case of Probably Specific Brain Tumor.—M. J. K., aged sixteen, applied to me November 24, 1885, with symptoms of cerebral tumor. Moderate doses of iodide of potassium and mercury pushed to its physiological indications not having produced any decided improvement by May 1st, I decided to push the iodide of potassium to the limit of tolerance. However, for ten days or two weeks before this, there had not been quite so much headache, and the nausea and vomiting had somewhat diminished. On May 3d the patient was ordered thirty grains of iodide of potassium three times daily, in plenty of water half an hour before her meals, the dose to be increased by five grains each succeeding day. By May 6th the dose had reached forty-five grains, and as there were no indications of iodism the dose was ordered to be increased by ten grains daily. By May 14th the patient had reached 3 ij three times daily, with no iodism, and the dose was ordered to be increased by twenty grains daily. This was continued until the patient was taking 3 iij three times daily. By this time the potassium had produced some gastric irritation, and the patient complained of cramp-like pains in the stomach when the medicine was omitted. No other evidence of iodism appeared, except that the flow of saliva had slightly increased. From this time on the patient very mate-

rially improved in every way except vision, the restoration of which we had not hoped for. Until the present time there has been no return of the symptoms. She has had no headache, no vomiting, no staggering of the gait in walking, no attacks of tremulousness or dizziness; general health is excellent, and she feels in every way well. Her menstrual function has been established within the last two months. Her patellar reflex, however, remains somewhat diminished, and the optic atrophy is almost complete.—*Med. News*, Feb. 12, 1887.

Porter (W. T.) on the Apparent Effect of Cinchonidia upon Syphilitic Periostitis Complicated by Intermittent Fever.—A male, age twenty-six, was admitted June 14, 1886. He said that about three years ago he contracted syphilis. Three weeks ago a malarial fever, which he contracted a month before in New Orleans, and which was seemingly "broken," returned. This attack was irregular but chiefly of a tertian type. During seven or eight days he has observed great tenderness over the sternum. About four in the afternoon of each day he has a sharp, sticking pain which he refers to the sternum. The pain is almost continuous, is increased by movement, and lasts during most of the night, being severest at midnight. The scars resulting from his rupial eruption are oval, whitish, and non-adherent. There are periosteal thickenings on sternum and tibiae.

The osteocopic pains began at the same hour as the malarial paroxysm, and the daily chill and fever ceased to recur when the pains became established. In order to determine, if possible, how far the malarial poison had influenced the specific element, the patient was given nothing but cinchonidia .4 grams ($6\frac{1}{4}$ grains) three times daily. Under this treatment he improved rapidly and, against advice, left the hospital a week later.—*Weekly Med. Rev.*, Jan. 1, 1887.

Jacobi (M. P.) on the Use of Quinine in the Pneumonia of Children.—The paper was based upon observations made in fifty-three cases occurring in dispensary practice. The ages of the children varied from six months to four years, the average being about two and a half years. The doses were ten grains daily, five at night and five in the morning. There were thirty-three unquestionable recoveries, and seven deaths, but the mortality

was doubtless more than seven per cent. The modification in physical signs, to which special attention was directed, pertained to the blowing respiration and tubular breathing. These disappeared during the use of the quinine in from two to seven days in twenty-nine cases; in from eleven to eighteen days in seven cases; and in one case after three weeks. The fever disappeared entirely in thirty-two cases; on the second day in eight cases; on the third and fourth day in three cases; on the fifth day in five cases, etc. In twenty-five cases, defervescence occurred within seven days from beginning the quinine; in seven cases, later.

The writer concluded that in the pneumonia of children quinine in daily doses of ten grains does not act as an antipyretic, but that it causes defervescence or arrest, temporary at least, of the morbid process. A forced defervescence would be of but little advantage in broncho-pneumonia.—*N. Y. Med. Record*, Jan. 29, 1887.

Ripley (J. H.) on the Value of Quinine as an Antipyretic in Pneumonia.—The conclusion arrived at was, that quinine is a feeble and uncertain antipyretic in pneumonia. But this is not all. It has a bad effect on the appetite and digestion, and not infrequently excites nausea and vomiting. In addition, it is liable to produce marked cardiac weakness, profuse cold perspiration, and profound nervous depression. Opisthotonos was noticed in one instance, and in many cases it caused epistaxis. These bad effects, he thought, more than counterbalanced any good effects that could be attributed to it.

Moreover, he could not see that it had shortened the natural course of the disease in any case. In some instances the pneumonic consolidation had extended under its use. In general, he believed, that too much importance is, at the present day, attached to the reduction of temperature in febrile diseases. That quinine has any effect in preventing cell migration, as alleged by certain authors, he thought was extremely doubtful. In conclusion, he expressed the opinion that large doses of quinine in pneumonia should be abandoned. If an antipyretic effect were desired, we possess much more efficient agents in antipyrin and salicylate of sodium.—*Med. News*, Jan. 29, 1887.

Rebory on the Phosphate of Lime in the Treatment of the Sweats of

Tuberculosis.—In a Paris thesis, 1886, the author, among other remedies, places phosphate of lime in the first rank in the treatment of night sweats. Its effect is undoubted, and continues during the next day.

It is toxic in no dose, easily administered, well borne by the stomach, relieves the diarrhoea which often accompanies the sweats, improves nutrition, and can be continued a long time not only without inconvenience but with real benefit to the health.—*Rev. de Thér.*, Feb. 1, 1887.

Antipyretic Action of Nitrogenized Air.—Dr. Francisco Valenzuela of Madrid, has made some observations (published in *El Siglo Médico*, Jan. 30, 1887,) on the effect of inhalation of nitrogen, or rather of air containing an abnormally large proportion of nitrogen, upon febrile diseases. He compared its action in reducing temperature with that of cold applications, quinine, antipyrin, digitalis, and arsenic, and concludes that the inhalation of nitrogen is the only method of treatment, the cessation of which for a day is not followed by a rise of temperature to its former height. It has also, he believes, a beneficial effect on the diseased process itself. The plan adopted was to administer the nitrogen in two daily sittings of from half an hour to an hour in duration, beginning with air containing 17.76 per cent. of oxygen, and gradually decreasing this proportion till at the close of the sitting it was reduced to 12 per cent. Some few details are given of a phthisical case in which it was tried. At first some dyspnoea was produced, but the evening temperature at once sank to normal, in addition to which the cough decreased, the blood almost entirely disappeared from the sputum, the sweats became less frequent, and the appetite improved. This patient had been previously treated by quinine, with but little good result. No other cases are reported, though several other patients were treated in this manner, most of whom are stated to have been benefited by it.—*Lancet*, Feb. 12, 1887.

A New "Cure for Cancer."—Dr. Velloso lays claim to having cured several cases of epithelioma of the face and lips with the juice of alvelos, a plant which belongs to the family of Euphorbiaceæ. It acted as an irritant, and destroyed the diseased tissue, which was quickly replaced by healthy granulations. Of the three differ-

ent kinds of alvelos (male, female, and wild), the second is considered the most efficacious. It is found at Pernambuco, and although the natives have employed the juice for some time, it has not come into extensive use on account of the severe pain which it causes. The best results were obtained with the juice in a concentrated solid form, and with the addition of vaseline or lanoline. This preparation should be applied with a brush to the affected part (previously washed with a solution of carbolic acid), which should then be left exposed to the air for at least an hour. It should afterwards be covered with lint. This treatment should, as a rule, be repeated every two or three days, and never more than once in twenty-four hours, as the pain of the application is severe. The treatment was more speedily successful when begun before ulceration has occurred.—*Brit. Med. Jour.*, Jan. 1, 1887.

MEDICINE.

Quinquaud on the Treatment of Eczema.—The treatment as set forth by Dr. Quinquaud at the St. Louis Hospital, Paris, consists chiefly of starch baths, applications of the glycerite of starch. And in rebellious cases and among children he employs an ointment of zinc oxide 1-20.

In eczema squamosum he paints the surface with silver nitrate strong enough to make a slough. In cases where there is much cracking of the skin a 1-5 solution of silver nitrate gives good results except in the acute stage, where emollients are indicated. In rebellious cases he uses lanoline. Eczema rubrum can be cured in three weeks by emollients. Other forms of eczema, characterized by a dry hypertrophic condition of the skin, are best treated by washing with solutions of caustic potash and applications of emplâtre de Vigo (lead plaster, wax, resin-ammoniac, bdellium, olibanum, myrrh, saffron, turpentine, liquid storax, and oil of lavender).—*La France Médicale*, Nov. 6, 1886.

Metcalf (J. T.) on a Successful Treatment of Acne.—I was led to employ chrysophanic acid in these cases, by reason of learning what it had effected when used as an ointment in treating chronic psoriasis. My habit is to begin with an ointment made of three grains of the acid to an ounce of vaseline. The face

is well washed with soap and dried, at night. Before going to bed, the parts in which acne exists are well rubbed with the ointment, and this is repeated, every night, until a sharp dermatitis with scarlet skin is produced. Inunction then ceases, until disappearance of the artificial inflammation of the skin, when a repetition of the ointment is made, under conditions above stated.

In all delicate skins the three-grain strength is sufficient. In others it may be necessary to increase the percentage of chrysophanic acid until sufficient dermatitic power is produced. Almost never have I been obliged to go beyond five grains to the ounce. It is necessary to caution patients that the bedclothes and garments be not stained by the ointment, and to have them wash the fingers well that the eyes may not be made to suffer. —*Boston Med. and Surg. Jour.*, Jan. 27, 1887.

Younge (G. H.) on the Etiology and Treatment of Chronic Tropical Diarrhœa.—My own experience convinces me that the disease always begins in a disordered state of the hepatic functions, and that the intestinal changes are only secondary.

In cases where I have been able to study the disease from the first I have always found that it begins as follows: It nearly always sets in at the commencement or end of the hot weather. In other words at the time when liver diseases are particularly prevalent. The disease begins with what may be called "hepatic dyspepsia." The patient suffers from loss of appetite and morning sickness. About an hour after meals he feels sick, and there is frequently retching and vomiting of a sour bilious fluid. Distressing flatulence occurs after the food has passed into the intestines. Then loose motions occur once or twice in twenty-four hours. At first, the stools vary from a pale clayey to a light green in color, and are fetid. Under ordinary circumstances they contain neither blood nor mucus. This stage may last from one to four months, during which time the health gradually deteriorates. In the second stage the bowels may be moved from four to six times, or oftener, in twenty-four hours. The stools are of a muddy gray or yellow color and very frothy, closely resembling yeast in appearance; and have a peculiarly sickly odor.

In all cases they show an absence, or at least a disordered secretion, of bile. At this time the tongue is of a bright-red color, and the surface is glazed. Towards the end, in fatal cases, it becomes deeply fissured and covered with aphthous patches. Emaciation takes place rapidly. During the second stage there are well-marked liver symptoms. The conjunctivæ are of a yellowish color. There is a sense of dragging and tenderness over the right hypochondrium; and on physical examination, the liver is found more or less enlarged.

All the symptoms show that the disease is due to an absence of the antiseptic and digestive actions of the bile. At the same time the digestion becomes impaired, and the antiseptic action of the bile ceases. This is followed by fermentation of the food in the intestines, and consequent flatulence and diarrhœa. In some cases the disease begins with acute bilious diarrhœa, the stools containing large quantities of dark inspissated bile. When this subsides the stools assume the characteristic yeasty appearance.

In the treatment of "Hill diarrhœa" our great object should be to cure the disease before any of these atrophic changes have occurred. The remedies to be used depend entirely on the time at which we see the disease. During the first stage we should direct our attention chiefly to the liver. I have found ammon. chlorid., ℥j. in inf. chirettæ, 3 j., given four times a day, most useful at this time. At bedtime I give the following pill: *R* Pulv. ipecac., gr. j.; pil. rhei. co., gr. iij.; ext. tarax., q.s. This treatment usually at once restores the secretion of bile, and the diarrhœa ceases. I then give nitro-hydrochloric acid with some carminative as an hepatic stimulant and general tonic. Counter-irritation over the liver with ung. hydrarg. iodi. rubri is very useful. Opium is nearly always injurious in the first stage of chronic tropical diarrhœa. When the disease has reached the second stage, I have found astringents not only useless but injurious. Astringents having failed in its treatment, I was led to try pepsin in "Hill diarrhœa." —*Med. Press*, Jan. 12, 1887.

A Recipe for Keeping One's Health in India.—A correspondent in Bombay, referring to a recent annotation on the "Health of Europeans in India," speaks of the difficulties by which young surgeons, especially army men, are surrounded. The

writer of this note having himself served in India, fully appreciates these, and, in reply, gives him the following sound recipe compounded by the Duke of Wellington, then Colonel Wellesley: "I know but one receipt," said he, "for good health in this country, and that is to live moderately, to drink little or no wine, to use exercise, to keep the mind employed, and, if possible, to keep in good humor with the world. The last is the most difficult, for, as you have often observed, there is scarcely a good-tempered man in India."—*Med. Press*, Dec. 29, 1886.

Clark (A.) on the Management of Simple Constipation.—1. On first waking in the morning, and also on going to bed at night, sip slowly from a quarter to half a pint of water, cold or hot. 2. On rising, take a cold or tepid sponge bath, followed by a brisk general towelling. 3. Clothe warmly and loosely; see that there is no constriction about the waist. 4. Take three simple but liberal meals daily; and, if desired, and it does not disagree, take also a slice of bread-and-butter and a cup of tea in the afternoon. When tea is used it should not be hot or strong, or infused over five minutes. Avoid pickles, spices, curries, salted or otherwise preserved provisions, pies, pastry, cheese, jams, dried fruits, nuts, all coarse, hard, and indigestible foods taken with a view of moving the bowels, strong tea, and much hot liquid of any kind, with meals. 5. Walk at least half an hour twice daily. 6. Avoid sitting and working long in such a position as will compress or constrict the bowels. 7. Solicit the action of the bowels every day after breakfast, and be patient in soliciting. If you fail in procuring relief one day, wait until the following day, when you will renew the solicitation at the appointed time. And if you fail the second day, you may, continuing the daily solicitation, wait until the fourth day, when assistance should be taken. The simplest and best will be a small enema of equal parts of olive oil and water. The action of this injection will be greatly helped by taking it with the hips raised, and by previously anointing the anus and the lower part of the rectum with vaseline or with oil. 8. If by the use of all these means you fail in establishing the habit of daily or of alternate daily action of the bowels, it may be necessary to take artificial help. And your object in doing this is not to

produce a very copious dejection, or to provoke several smaller actions; your object is to coax or persuade the bowels to act after the manner of nature by the production of a moderate more or less solid formed discharge. Before having recourse to drugs, you may try, on waking in the morning, massage of the abdomen, practised from right to left along the course of the colon; and you may take at the two greater meals of the day a dessertspoonful or more of the best Lucca oil. It is rather a pleasant addition to potatoes or to green vegetables. 9. If the use of drugs is unavoidable, try the aloin pill. Take one half an hour before the last meal of the day, or just so much of one as will suffice to move the bowels in a natural way the next day after breakfast. If it should produce a very copious motion, or several small motions, the pill is not acting aright; only a fourth, or even less, should be taken for a dose. When the right dose has been found it may be taken daily, or on alternate days, until the habit of daily defecation is established. Then the dose of the pill should be slowly diminished, and eventually artificial help should be withdrawn. The aloin pill is thus composed: $\mathcal{R}$ Aloinæ, $\frac{1}{4}$ gr.; extr. nucis vom., $\frac{1}{4}$ gr.; ferri sulph., $\frac{1}{4}$ gr.; pulv. myrrhæ, $\frac{1}{4}$ gr.; saponis, $\frac{1}{4}$ gr.; fiat pil., 1. If the fæces are dry and hard, and *if there is no special weakness of the heart*, half a grain of ipecacuan may be added to each pill. Should the action of the pill be preceded by griping and the character of the action be unequal, half a grain of fresh extract of belladonna will probably remove these disadvantages. If the aloin pill gripes, provokes the discharge of much mucus, or otherwise disagrees, substitute the fluid extract of cascara sagrada, and take from five to twenty drops in an ounce of water either on retiring to bed or before dinner. And when neither aloin nor cascara agrees, you may succeed by taking before the mid-day meal two or three grains each of dried carbonate of soda and powdered rhubarb.

The exact agent employed for the relief of constipation is of much less importance than its mode of operation. If, whatever the agent may be, it succeeds in producing after the manner of nature one moderate formed stool, it may be, if necessary, continued indefinitely without fear of injurious effects. But treated upon physiological considerations, I have the belief that in the

great majority of cases simple constipation may be successfully overcome without recourse to aperients.—*Lancet*, Jan. 1, 1887.

Marten on Death following soon after Washing out Dilated Stomach.

—The patient was forty-eight years old, and seven years previously had been an in-patient, with symptoms of pyloric ulcer. His stomach was now much dilated, and he suffered from flatulence, vomiting, pain, and increasing weakness. He vomited large quantities of frothy fluid, containing sarcinæ. Ten days after admission it was decided to wash out the stomach. Soon after passing the tube into the stomach the patient became very faint, so it was withdrawn. About two hours afterwards he complained of stiffness in the jaws, with inability to open the mouth, and rigidity in the arms, which were strongly pronated and flexed, the thumbs being turned on to the palms. The patient was conscious, and sweated profusely. The rigidity spread to all the muscles of the limbs and trunk, and the temperature rose to 103.4°. He became pulseless and livid, the temperature rising to 107.2° before death, which occurred six hours and a half after washing out the stomach. Post-mortem examination showed a simple stricture of the pylorus, with the scar of an old ulcer, and a much-dilated stomach. There was no injury or abrasion of the mucous membrane. The other organs were healthy, and no lesion of the brain was discovered.—*Lancet*, Jan. 8, 1887.

Smith (Q. C.) on the Treatment of Acute Sporadic Dysenteries.—When the patient is first seen, careful inquiry should be made as to the character and amount of the alvine evacuations at the commencement, and for one or two days prior to the beginning of the disease, careful palpation of the abdomen should be made, to ascertain if there be retained solid fæcal accumulations in the bowel.

If the history of the case, or palpation, reveals that there are retained solid fæcal matter in the bowel, and the patient be not much prostrated, then phosphate of soda should be given, one or two full doses, so that the bowels move freely once or twice; but no further purgation should be induced during the treatment of the case. But purgation, preliminary or otherwise, is rarely indicated in the treatment of dysenteries.

However, such medicines as aloes,

colocynth, and phosphate of soda, if given in *minute* doses, often produce decided benefit, especially in the treatment of the acute sthenic forms of dysenteries.

The remedies we have found most useful, in the treatment of acute dysenteries are as follows: Belladonna, capsicum, ipecac, gelsemium, aconite, iodine, nux vomica, spirits of turpentine, cinchona, baptisia, aromatic spirits of ammonia, salicin, lupulin, logwood, sub-nitrate of bismuth, and vegetable charcoal.

To quickly relieve an ordinary case, we would begin by immediately giving a hypodermic of $\frac{1}{10}$ to $\frac{3}{10}$ grain sulph. atropia; cover the abdomen with dry, thick, hot cloths, applying soothing liniment to the abdomen, if their be great pain; frequent *small* drinks of cool, acidulated drinks, or plain water. Soon the patient will be greatly relieved of pain, and the stomach in retainable condition. Then, say one hour after the hypodermic, begin the administration of something like the following:

℞ Fl. ex. belladonna	3 i.
Green tinct. gelsemium	3 ii.
Tinct. aconite root. (Fleming's)	gtt. iv.
Arom. spts. ammonia	$\frac{1}{2}$ ss.
Elix. dactopeptine, q. s. ft.	$\frac{3}{4}$ ii.

Mix; make solution.

SIG.—Teaspoonful every one to three hours, as may be required to control pain in the bowels.

Also;

℞ Ex. cinchona	
Ex. lupulin, aa.	gr. xii.
Ex. capsicum	gr. ii.
Ex. ipecac	gr. iv.

Mix; make twelve pills, and silver coat.

SIG.—One pill three times a day, preferably just after meals.

Should the renal secretion be suppressed, or notably diminished, spirits of turpentine, prepared as follows, would be in order:

℞ Gum acacia	
Sugar of milk	
Pure sugar, aa.	3 i.
Oil sassafras	gtt. iv.
Chloroform water	$\frac{1}{2}$ ss.

Mix well, and add

℞ Fl. ex. ipecac	gtt. ii.
Cinnamon water, q. s. ad	$\frac{3}{4}$ ii.

Mix; make emulsion.

SIG.—Teaspoonful every two hours, until renal secretion is restored.

If the evacuations are fetid, vegetable charcoal, spirits of turpentine, and baptisia are in order. If diarrhœa be present, salicin, sub-nitrate of bismuth, and logwood would be appropriate. In malarial dysentery cinchona, iodine, ipecac, and arsenic would be specially indicated.

Only one or two kinds of food at a meal should be allowed.—*Southern Clinic*, Feb., 1887.

Holt (L. E.) on the Antiseptic Treatment of Summer Diarrhoea.—

1. Summer diarrhoea is not to be regarded as a disease depending upon a single morbid agent.

2. The remote causes are many, and include heat, mode of feeding, surroundings, dentition, and many other factors.

3. The immediate cause is the putrefactive changes which take place in the stomach and bowels in food not digested, which changes are often begun outside the body.

4. These products may act as systemic poisons, or the particles may cause local irritation and inflammation of the intestine.

5. The diarrhoeal discharges, *at the outset* at least, are to be looked upon as salutary.

6. The routine use of opium and astringents in these cases is not only useless, but, in the beginning particularly, they may do positive harm, since, by checking peristalsis, opium stops elimination and increases decomposition.

7. I do not deny nor undervalue opium in many other forms of diarrhoea than the one under discussion.

8. Evacuants are to be considered an essential part of the antiseptic treatment.

9. Experience thus far leads me to regard naphthalin and the salts of salicylic acid as the most valuable antiseptics for the intestinal tract.—*N. Y. Med. Jour.*, Jan. 29, 1887.

Hays (G. D.) on Artificial Alimentation.—The author concludes :

1. That many pathological processes arise from an improper dietary, and many others may be controlled by a proper dietary.

2. Malassimilation is a cause of disease. Peptones in the general circulation being poisons, when from any cause metabolism is interrupted, the system is prone to take on pathological conditions.

3. In pyrexia : A. The digestive juices, being less in quantity and impaired in quality, should be re-enforced by the artificial digestive ferments.

B. The stomach is feeble in a muscular sense, and incapable of dealing with large quantities. Hence concentrated or predigested foods should be furnished it.

C. The process is one of tissue destruction (histolytic). Hence we must furnish

the materials for repair (histolysis). How and when to furnish these is still a disputed question.

D. Feeding is not the cause of pyrexia, nor starvation its cure. Though the former augments it and the latter decreases it, we gain most by keeping up nutrition.

E. The excess of urea excreted is not proof of nitrogenous waste in the blood.—*N. Y. Med. Jour.*, Jan. 29, 1887.

Sevestre on a Form of Infectious Broncho-Pneumonia of Intestinal Origin.—

The author concludes that in children from one to two years old, and probably older, there is brought on, by improper food, a decomposition of the intestinal contents which results in a fetid diarrhoea and infectious enteritis. Following this there may come on a general infection accompanied by pulmonary congestion and broncho-pneumonia.

Intestinal disinfectants, especially calomel and naphthaline, are the best means of checking the diarrhoea and preventing pulmonary complications. Proper diet is, of course, of prime importance.—*Gaz. hebdomadaire*, Jan. 21, 1887.

Bond (C. S.) on the Manner in Which Perforation of a Bronchus is Brought about in Empyema.—

Mr. Marshall has shown that when an empyema perforates the chest wall, the tendency is for it to do so in front—namely, between the fifth and sixth costal cartilages, where the muscular interspaces are thinnest and weakest. Now, in cases of empyema which I have observed, in which perforation of a bronchus has occurred, the collection of pus has been chiefly at the posterior part of the chest, and often limited to that area by pleural adhesions—being shut off, of course, from the anterior part of the thorax, where the chest wall is thin. In fact, it would appear that the seat of election for perforation is in front, in the case of the chest wall, and in the case of the lung, at the back, somewhere near the posterior border and below the level of the root. The following observation may suggest an explanation of this fact. If a vertical antero-posterior section be made of a lung compressed by pleural effusion, it will be seen that the larger tubes, both bronchi and pulmonary vessels, are arranged in a closely packed semicircle, with its convexity towards the spine ; further, that this line of the openings of the tubes is considerably nearer the posterior than the anterior

border of the lung, and also that the tubes are more closely packed below than above. Any pressure therefore exerted on the lung tissue from without, as in the case of an empyema, would act most powerfully on this portion of the lung, compressing it against the rigid bronchi, which lie at this spot just beneath the surface, while, in addition, the thickness of the elastic cushion is less, and the distance between the surface of the lung and an air-tube of any size is shorter here than in other parts of the lung.

Speaking generally, then, an empyema situated at, or having access to, the front of the chest will, if left alone, discharge by perforation of the chest wall; whereas one occupying the back part of the pleura will probably, under similar circumstances, perforate the lung.—*Lancet*, Jan. 22, 1887.

Carpenter (W. M.) on the Clinical Significance of Endocardial Murmurs.—The author expresses the belief that the *pathological* significance had overshadowed the *clinical* significance of endocardial murmurs, and therefore the terms "endocardial murmur" and "valvular disease of the heart" had been very frequently used synonymously.

The interest in the paper centred in the following propositions and conclusions:

Propositions: 1. The only definite relation between endocardial murmurs and valvular disease of the heart is that of determining exactly where the lesion exists. Even this has limitations.

2. Clinical studies and pathological observations have determined that no definite ratio exists between endocardial murmurs and the amount and gravity of valvular disease. A very loud murmur may accompany a very small amount of disease, and, *per contra*, extensive valvular and organic disease of the heart may exist unaccompanied by any cardiac murmur.

3. Endocardial murmurs, when present, enable us, as a rule, to ascertain definitely which auriculo-ventricular opening is involved. They may indicate the amount of damage which the valves have sustained.

Conclusions.—*First.*—That endocardial murmurs and chronic valvular disease of the heart are not synonymous terms.

Second.—That the existence of a persistent endocardial murmur is not inconsistent with long life and the enjoyment of a fair degree of health.

Third.—That the knowledge, on the part

of the patient, of the presence of an endocardial murmur should guard him against exposure to all influences that may give rise to any of the diseases which are liable to have cardiac disease as a sequel, or that will cause increased cardiac action.—*N. Y. Med. Record*, Feb. 5, 1887.

Loomis (A. L.) on Paroxysmal Cardiac Dyspnoea.—In many cases of cardiac hypertrophy and dilatation dyspnoea is a prominent symptom. It is often of gradual development, and depends rather upon secondary pulmonary and renal changes than upon the cardiac lesion.

In the cases of which he wrote, the dyspnoea is due to influences existing within the heart. Its one essential cause is a temporary or permanent arrest of the blood within the heart and pulmonary arteries, which is either paroxysmal or it will speedily terminate in death. The primary cause is gradual failure of organic power of the heart, and the exciting cause is any thing which will lead to undue cardiac action. The symptoms consist in the sudden development of dyspnoea, with pale countenance, feeble pulse, intermittent and irregular cardiac action, cold sweat, sense of extreme distress in the chest. Cardiac murmurs are not present; cardiac impulse is feeble; no evidence of valvular insufficiency; urine negative; and entire absence of pulmonary disease. Degeneration and thinning of the cardiac walls has been the most constant lesion; first, and most advanced, in the right ventricle. The essential feature of treatment consisted in regulation of diet, and a careful regulation of exercise in the open air. Medicinally, alkalies, preparations of iron combined with small doses of digitalis.—*N. Y. Med. Record*, Feb. 5, 1887.

Dacryorrhœa in Tabes Dorsalis.—M. Féré has recorded a case in which unilateral dacryorrhœa, a profuse secretion from the lachrymal gland, was occasionally noted in a patient suffering from locomotor ataxy, in whom many of the most characteristic symptoms of the disorder were present. The flow of tears from one eye supervened apart from any evident disturbing cause, external or otherwise, and disappeared as suddenly. Sometimes it was accompanied by pain on the side of the affected eye. There can be no doubt that it was the result of some temporary nerve-disturbance, comparable with those producing the other crises of tabes, such

as the gastric, the renal, and so forth.—*Brit. Med. Jour.*, Jan. 22, 1887.

Ralfe on Phosphatic Diabetes.—All the cases reported, with the exception of two, were young adult males. The symptoms common to all were great emaciation, aching rheumatic pains in loins and pelvic regions, dry, harsh skin, with tendency to boils, and ravenous appetite; in some cases cataract develops. In the majority there was polyuria; in others the urine was normal in quantity, with a high specific gravity. The urea was increased in some cases slightly, in others to a greater extent; but the great feature of all the cases was the very considerable and constant elimination of phosphoric acid, with or without increase of the constituents of the urine—a feature which distinguishes it from insipid diabetes on the one hand and azoturia on the other, with both of which it has been improperly confounded. The pathology depends not so much on increased metabolism of nervous matter as on defective nutrition, so that the tissues are not able to utilize the phosphorus brought to them, and consequently a greater amount passes through the system daily. In those cases, in which an excessive excretion of phosphoric acid replaces saccharine diabetes, it is probable that acids like oxy-butyric-glycollic, etc., formed by imperfect oxidation of the sugar, dissolve out the earthy phosphates from the tissues, which appear in excess in the urine. As regards the prognosis in these cases, it is most unfavorable in the first two groups; country air, massage, cod-liver oil, may for a time do good, but the patients rapidly fall back, and either are carried off by some acute attack proving fatal in their exhausted condition, or drift on into phthisis, or into diabetes mellitus.—*Lancet*, Jan. 15, 1887.

Metcalf (J. T.) on the Treatment of Sciatica.—Some months ago I got my druggist to make tablet-triturates, each of which contain three drops of the following mixture:

Tincture of aconite root	} Equal parts by volume.
“ “ seeds of colchicum	
“ “ belladonna	
“ “ actea racemosa	

Of these, I give one every four, six, or eight hours, according to the necessity of the case. It takes not long to impress the system, especially with the aconite, nor does it, as a rule, require more than three

days to make the patient so firmly believe in its efficacy that he has no need of persuasion to ensure its continuance until complete relief.

In neuralgia of the axillary and brachial nerves, it has proved quite as efficacious as in that of the great crural branch.—*Boston Med. and Surg. Jour.*, Jan. 27, 1887.

Spitzly (J. H.) on Post-Mortem Irritability of Muscle.—A young Hindoo, aged twenty, was admitted into our wards on Feb. 28, 1886, and died on Oct. 31st of phthisis pulmonalis. He was a remarkably thin and weakly-looking individual; but although he had a decidedly phthisical aspect, and suffered from cough, general emaciation, and diarrhoea, no dullness was perceptible on percussion of the chest walls. The post-mortem examination revealed a large vomica with infiltrated edges, situated at the root of the left lung, which sufficiently accounted for our inability in detecting any marked alteration on percussion. Numerous small abscesses were also found throughout the substance of the left lung. The intestinal walls were of a dull clay color. A most peculiar phenomenon in connection with the voluntary muscles, however, more especially attracted our attention. About two hours after death had taken place, one of our students, who was inspecting the body, percussed the pectoral region, and, to his great astonishment, noticed that the muscles responded most energetically to the stimulus conveyed by the percussing finger, and contracted very promptly. On examining the muscles, I was able to produce most vigorous contractions of the biceps and flexor muscles of the arms, the pectorals, the sterno-cleido-mastoids, the masseters and temporals, and also of the rectus femoris and other muscles of the lower extremity. The biceps and pectorals, especially, responded very promptly, and the contracting muscular fibres of the biceps in some instances rose to certainly half an inch above the level of the quiescent portion. The muscular substance itself was very soft and doughy to the feel, and of a pink color. Although I have very frequently seen a stimulus call forth fibrillary muscular contractions in emaciated persons suffering from phthisis, I have never before observed the same phenomenon in such a remarkable degree of intensity on the body of a person in whom life had already been extinct for two hours, and I should be much interested to know

if this post-mortem phenomenon is common in cases in which the patient has very gradually succumbed to a chronic exhausting disease. Perhaps I should also add that the temperature at the time these observations were made was 90° F., and that the time of the year was what is here called the "dry season."—*Lancet*, Jan. 15, 1887.

DISEASES OF THE NOSE AND THROAT.

ABSTRACTS AND SELECTIONS

By C. H. KNIGHT, M.D.

Transformations of Mucous Polypi into Malignant Tumors (Carcinomatous or Sarcomatous).—In 1855 Billroth published an article upon the structure of mucous polypi, in which he scouted the idea of a metamorphosis of these simple growths into malignant tumors. In 1876 Michel reported a case, and in 1885 Hopmann described a second, both of which seemed to indicate that this change had actually taken place. Schmiegelow (1885) related some observations made by Schaeffer. But in all these cases some links are wanting from the chain of evidence. In a case reported by Bayer (*Rev. mens. de laryngol., d'otol., et de rhinol.*, Jan., 1887) the proof seems to be complete, since the nasal tumor, removed with the cold-wire snare, consisted of a villiform carcinoma implanted by a broad base upon a simple mucous polyp. Microscopic examination confirmed the diagnosis. Freedom from recurrence after the lapse of two years shows the absence of malignant infiltration of the wall of the nasal passage, and indicates genuine transformation from benign to malignant character in a primary nasal myxoma.

Three Cases of Suppuration of the Frontal Sinus.—Three cases of suppuration of the frontal sinus, or empyema of the frontal sinus, as they are called by the author, Dr. Borthen, are reported in the *Revue Internationale des Sciences Médicales*, 1886, No. 34, *London Medical Record*, December 15, 1886. Case 1. Woman, aged fifty-six. The disease began two or three years ago with headaches almost continual, and so violent as to cause vomiting. Intense coryza followed. After some time a tumor slowly developed at the internal angle of the orbit. Examination: right eye looks

down and out, slight exophthalmos, right pupil about one centimetre lower than left; peculiar physiognomy. Between the lachrymal sac and the globe of the eye is a swelling about three centimetres long, which is felt within the orbit as far as the finger can reach; fluctuation; skin normal. Slight pain on pressure below eyebrow, but no sign of cerebral compression. Movements of eye impeded, no diplopia, vertigo on closing sound eye. Thick pus escaped on exploratory puncture. Treatment: incision; evacuation of four or five teaspoonfuls of thick yellow pus; washing out with a solution of salicylic acid, and drainage, a little silver tube being left in the wound. Improvement rapidly followed, but there was still a slight discharge. Case 2. Woman, aged fifty. Tumor at internal angle of orbit; no deviation of eye. Severe headaches preceded tumor. Treatment as above; incision, emptying, and drainage. Cure in a fortnight. Case 3. Woman, aged thirty-three. Disseminated choroiditis and slight swelling in left orbit, internal half. Elastic tumor felt within orbit. Left eye six millimetres lower than right. Diplopia on looking to right. Headaches and violent pains in back of neck. Sleeplessness, nausea, anorexia. Treatment: skin incised, and tendon of superior oblique muscles reached and divided. Cyst punctured and washed out with a four-per-cent. boric-acid solution. Between one and two ounces of yellowish viscous fluid escaped. Drainage. An intense coryza came on some days after operation. The abscess healed, but slight diplopia persisted.—*Boston Med. and Surg. Jour.*, Jan. 20, 1887.

Two Cases of Chronic Abscess of the Antrum Simulating Chronic Nasal Catarrh.—In the first of these cases there were no symptoms pointing directly to disease of the antrum, but percussion over the right cheek bone with Flint's hammer and fleximeter gave a peculiar dull, cracked sound quite different from the clear resonance obtained on the opposite side. In the second case, the difference on percussion was less marked, but on inspection of the nasal cavity discharge could be seen coming from the opening into the left antrum just above the inferior turbinated body. The author concludes that antral disease should be suspected in cases of chronic nasal catarrh not dependent on obstruction or other

discernible cause. A positive diagnosis may be made when the discharge can be seen oozing into the nasal cavity from the antrum. A probable diagnosis may be drawn from a difference in percussion resonance on the two sides. Additional evidence is furnished by diseased or tender teeth on the suspected side. Such teeth should be extracted, an opening drilled into the antrum, and the cavity washed out. No special harm has been done by such an operation, even if the antrum is found to be healthy. The treatment of antral disease consists of free opening, antiseptic irrigation, drainage with a tube, and, if necessary, a counter-opening from inferior meatus into antrum.—*North Carolina Med. Jour.*, Jan., 1887.

New Operation for Fistula of the Hard Palate.—The advantages claimed for a "new method of muco-periosteal uranoplasty," suggested by Dr. Clayton Parkhill, in the *Trans. of the Colorado State Med. Soc.*, 1886, are ease of performance, absence of tension upon the flaps, and abundant blood and nerve supply to the flaps in consequence of the peculiar direction of the incisions which form them. In the original paper reference is made to the operations of Pancoast and of von Langenbeck, and diagrams are given showing their methods and also that of the author. Parkhill's operation may be briefly described as follows: Chloroform is given in preference to ether, for the reason that the sutures are very likely to tear through during the act of vomiting which frequently follows the inhalation of ether. The head is thrown back by means of pillows beneath the shoulders, so that the effused blood may collect in the fauces and posterior nares. The edges of the opening having been pared, an incision is made from its anterior extremity curving forward and outward, and running near the alveolus to a point on a plane with the posterior limit of the opening. A similar curved incision, with its convexity backwards, begins at the posterior extremity of the opening, and runs along the opposite side of the roof of the mouth, ending opposite the anterior margin of the opening. The anterior flap, with its complexity forwards, is dissected up by means of an ordinary bone-elevator. The posterior flap is raised by means of a blunt instrument shaped somewhat like a much-curved retractor. The periosteum

is included in the flaps. The flaps thus formed are drawn together in the middle line with sutures of fine silver wire or iron-dyed silk. They are introduced diagonally, so that subsequent swelling will tend to approximate the puncture points. The after-treatment consists of plugging the nostrils with cotton in order to compel mouth-breathing, irrigation twice a day with a disinfecting solution, and avoidance of solid food. The œsophageal tube may be used, and the sutures should not be disturbed until union is assured. The author has resorted to this method in only one case, which proved a failure in consequence, in his opinion, of premature removal of the sutures.

Gummatous Infiltration of the Tongue.—Four cases of the above lesion were reported by Dr. Urban G. Hitchcock, at the last meeting of the American Laryngological Association.

In reviewing these cases, it is to be remarked that in no one of them was the fibrous septum of the tongue the exclusive seat of the deposit, which has been declared to select this tissue for its development, and that in three of the cases the deposit did not at all approach this structure. In no instance was there neighboring glandular enlargement. As might, perhaps, be anticipated, the degree of dysphagia produced by the growths was in direct proportion to the proximity of the deposit to the base of the tongue. Whether this is generally true does not appear from any works consulted. As far as these cases go, they bear out the assumption which has been made to the effect that the soft palate and tongue are never simultaneously involved in ulceration.—*N. Y. Med. Jour.*, Feb. 5, 1887.

Chronic Laryngitis and its Sequelæ.—Dr. G. Hunter Mackenzie contributes a very interesting and practical paper on the above subject to the Jan. number of the *Edinb. Med. Journal*. The author distinguishes between *primary* and *consecutive* chronic laryngitis, the latter including those cases which are met with in the course of zymotic and specific diseases, in malignant disease, in pulmonary phthisis, and as a result of extension from the nares or pharynx. After describing the laryngoscopic appearances and the clinical history of the disease, its most unfortunate sequel, tuberculosis, is referred to, and a case in illustration of this course of devel-

opment is cited. The laryngoscopic characters indicating that a simple laryngitis has become tubercular are by no means pathognomonic. A correct diagnosis in the early stage can only be reached by microscopic examination of the sputum and laryngeal secretion. The presence of tubercle bacilli is the only positive proof. They may come from the lungs at the outset, but sooner or later a chronic laryngitis associated with pulmonary tuberculosis will become tubercular. The formation of new growths is another of the sequelæ of chronic laryngitis. The neoplasms may be, according to their seat of origin, papillomatous, mucous, fibrous, or cartilaginous. The early symptoms are those of an exaggerated degree of chronic laryngitis, and depend upon the number, size, and situation of the growths. The laryngoscope is essential to correct diagnosis.

It is impossible to discover the causes which determine the course of a chronic laryngitis. In general the more chronic the inflammation, especially in the presence of a constitutional tendency, the greater the danger of tubercular degeneration; the greater the disposition to localization of the inflammation, the more marked is the tendency to new-growth formation. At certain stages it may be utterly impossible by mere inspection to distinguish between simple chronic laryngitis and tubercular, malignant, or syphilitic disease. Microscopic examination is indispensable, but here great caution is needed, since, even in malignant disease, pieces artificially or spontaneously detached may present the characters of inflammatory or granulation tissue. Without discarding general and climatic treatment, the author vigorously insists upon the importance of local applications by means of inhalations, sprays, powders, and pigments. Of the last mentioned, nitrate of silver is the best, in aggravated cases, commencing with a solution of 30 grains to the ounce, increasing every ten or fourteen days by 30 grains, until a strength of 120 grains or more to the ounce is reached. These pigments are applied at first three times and then twice weekly, for a period of seven months.

A co-existent chronic nasal catarrh must not be overlooked. Solvent sprays (a teaspoonful of bicarbonate of soda to the ounce of water), followed by an astringent spray of sulphate of zinc or acetate of lead,

one or two grains to the ounce of water, are of service, and in granular pharyngitis the enlarged follicles may need to be touched with London paste or the galvano-cautery.

In the event of formation of distinct new growth local treatment is futile, and the neoplasm must be removed by means of the forceps of Morell Mackenzie or the hollow bougies of Schroetter. When the growth forbid, thyrotomy must be resorted to. A tendency to recurrence is also an indication for more radical treatment than can be effected by intra-laryngeal means.

Operative Closure of a Large Laryngeal Fistula.—This interesting case was reported by Dr. Abbe at a meeting of the New York Surgical Society. The patient was a man, forty-five years of age, with an opening into his larynx just above the vocal cords, whose action was plainly visible on attempts at phonation. Speech was impossible while the fistula remained uncovered, but when closed by means of a flat pad phonation was perfect, though slightly husky. This condition was the result of a wound received by falling upon a shoemaker's knife, seven months previous. The patient was tracheotomized after the accident, and wore a tube for one month. Six ineffectual attempts had been made to close the opening in various ways. As a result the edges of the fistula, which was large enough to admit the tip of the thumb, had become cicatricial and indurated. Dr. Abbe succeeded in closing it by means of the following plastic operation: The edges of the fistula were thoroughly pared. A broad elliptical space was then included between two incisions, being somewhat wider than the fistula, and extending obliquely downwards on the patient's neck. A part of the included skin below the fistula was dissected up so as to make a flap hinged on its upper edge, which, when turned over, more than covered the hole. The cuticle was then removed from the surface not needed to cover the fistula, and the rest of the elliptical space made raw for the reception of the overturned flap. The latter was then stitched over the fistula by two rows of fine continuous catgut—one row, on the edge of the orifice, tacking the surface of the flap at the circle of denudation; and the second, on the outer edge of the flap, fastening it to the outlying cellular tissue.

The skin on either side of the neck was

then undermined and slid over the flap mentioned so as to meet directly over its centre. A lateral slash, one inch and three quarters away, was necessary to relieve tension, and served to admit a drainage-tube.

The patient made a perfect recovery, primary union taking place throughout the wound.

The trachea-tube, which had been introduced in a preliminary tracheotomy, was removed on the fifth day, and at the end of a week speech was permitted.—*N. Y. Med. Jour.*, Jan. 22, 1887.

The Surgical Treatment of Paralytic Laryngeal Stenosis.—In a communication to the *Brit. Med. Jour.*, Jan. 15, 1887, apropos of a suggestion made by Dr. G. B. Hope¹ with reference to this subject, Dr. Felix Semon recalls attention to the fact that paralysis of one abductor never of itself impairs respiration, and he decidedly objects to ablation of the cord in these cases. In cases of bilateral paralysis, rather than incur complete loss of voice which would of necessity result from removal of the cords, he much prefers the introduction of a trachea tube with a valve permitting phonation when desired. It is not true that permanent wearing of a tube shortens life. Of two patients, on whom he performed tracheotomy for bilateral paralysis eight years ago (*Clin. Soc. Trans.*, vol. xii., p. 184), the one is alive and in robust health; the other only succumbed in the course of last year to the fundamental disease (tabes dorsalis). Quite recently, a patient was shown at the Berliner Charitéverein, who has worn a tracheal tube for twenty-four years (*Berliner klin. Wochenschrift*, November 4, 1886).

Intubation, even in cases of acute laryngeal stenosis, must be regarded as still on trial. The difficulty of introducing the tube, the necessity of constant experienced supervision, and the possible occurrence of ulceration and even of perichondritis seem to render intubation unwarrantable in cases of chronic stenosis.

A Practical Hint for Tracheotomy.

—Let the surgeon place his left hand, as widely expanded as possible, over the neck of a child in the position for tracheotomy; then resting the fingers upon one and the thumb upon the other side firmly upon the skin, as far to the side of the neck as they

will reach, gradually draw in the thumb and fingers, and the skin (and loose tissue underneath) with them, towards the median line; as the sides of the windpipe are approached, a little more pressure, made in a backward direction, will place the thumbs and fingers in a position in which they almost meet behind the larynx, which is thus firmly held by the encircling hand in a position in which all the great blood-vessels, etc. (which have been wounded), and the vertebral bodies (which, it is recorded, have *blunted a knife-point*), are far out of harm's way, the windpipe itself starting forward and standing out prominently under the skin, which is yet fairly stretched (and can be stretched more tightly) over the site of incision, and lying both as superficially as could be desired and as perfectly under control as possible.—W. L. Braddon in *London Lancet*, Nov. 20, 1886.

Extirpation of the Larynx without Preliminary Tracheotomy.—This case, reported by Jordan Lloyd, is interesting from the fact that no preliminary tracheotomy was performed. The larynx was freed from all lateral attachments before the air-tube was opened. The trachea was divided just below the cricoid cartilage with Paquelin's cautery, and plugged with a large bent glass tube, through which the administration of the chloroform was continued during the operation. The thyroid cartilage was split in the middle line, and the lateral halves rapidly removed with scissors without much loss of blood, the superior laryngeal arteries being the only vessels requiring a ligature. The condition for which the operation was done was originally supposed to be epithelioma. The patient was a brass-worker, fifty-one years of age, and had been troubled with dyspnoea for twelve months, with cough and expectoration, and marked emaciation. With the laryngoscope a cauliflower-like growth was seen springing from the left side of the larynx and below the false cords. There were no enlarged glands, and the lungs presented nothing abnormal, except a few bronchial râles. Six days after the operation the patient died with broncho-pneumonia. Examination of the larynx showed a large intra-laryngeal growth, probably tubercular. The lungs showed purulent bronchitis extending into the smallest bronchioles, infundibula, and pulmonary acini, and were everywhere studded with miliary tubercles. The au-

¹ See MED. ANALECTIC, Jan., 1887, p. 23.

thor regards the operation as a serious surgical experiment, and seems to be in doubt as to whether it will ultimately be considered justifiable in any case.—*London Lancet*, Jan. 15, 1886.

Cases of Syphilitic Disease of the Larynx in Children.—Schaetz reports, in the *Deutsche med. Wochens.*, five cases of laryngeal syphilis in children of from nine to fifteen years of age. The lesions of the palate, throat, and larynx were similar to those seen in adults. Glandular swellings, affections of the bones, and changes in the cornea and incisor teeth were also present. Previous syphilis in the father was ascertained in all cases. All but one of the children were the first-born in their respective families. Specific treatment was successful. — *Lond. Med. Rec.*, Jan., 1887.

SURGERY.

Laidley (J. B.) on Traumatic Abscess of the Brain.—A boy of sixteen years of age placed a loaded shell loosely in a vise, and attempted to dig out the cap, which, of course, exploded, sending the contents of the shell into the floor, while the shell itself struck the boy in the forehead. The shell had trephined the frontal bone on the left side, driving the button of bone through the membranes into the brain. This piece of bone was removed with forceps, as were lacerated portions of the brain. The boy at once became conscious, and did well for a week, when his temperature rose to 102° and a small tumor began to protrude from the wound. Thirty-three days after the injury this hernia, which was then the size of a large egg, was removed. "I found the cerebral matter below this tumor discolored and angry-looking; again applied a compress and bandage. The substance removed consisted of softened cerebral matter, infiltrated with blood and lymph," the author says. On the same day the boy had a chill lasting thirty minutes. For four weeks afterward there was a profuse watery discharge from the wound, but no recurrence of a hernia. The patient died in coma at the end of that time. The "autopsy revealed a large pus cavity behind the seat of injury, and a small collection of pus in the frontal lobe of the right hemisphere." — *The Med. Record*, Dec. 25, 1886.

(Considering the condition of the wound at the time of the removal of the hernia and the occurrence of a chill at that time, one would think that the introduction of the needle of a hypodermic syringe to search for pus would have been a justifiable procedure.—G. B. P.)

MacEwen on Excision of the Laminae of Portions of the Spinal Vertebrae.—Two patients were shown at the Glasgow Pathological and Clinical Society, who had undergone the above operation.

In the first case there was complete motor and sensory paralysis of the lower limbs, with spastic contracture and absence of reflex action due to pressure on the cord in the dorsal region, where the vertebrae had become ankylosed in very acute angular curvature. On the fourth day after the operation (which is not described in the report) the patient had complete continence of urine and feces. When shown, the patient could freely move her lower limbs and had walked a quarter of a mile to report at the meeting.

The second case was one of fracture of the dorsal vertebrae by direct violence, and causing complete motor paralysis of lower extremities and incontinence of urine and feces. Three weeks after the accident there was marked atrophy of the muscles, increasing contractures, and no electrical contractility. Pressure sores soon developed, and urine was thick and ammoniacal.

Two of the laminae were found driven into the spinal cord, and were elevated. Nine months later, able to walk and freely move lower extremities. No incontinence. — *Bristol Med.-Chir. Jour.*, Dec., 1886.

G. B. P.

Davidson (J. F.) on a Case of Spina-Bifida; Cure Obtained by a New Method after Rupture of the Sac.—In March, 1885, Mrs. D. was delivered, after a normal labor, of a male child considerably above the average weight. A spina-bifida was at once detected in the region occupied, or supposed to be occupied, by the fourth and fifth lumbar vertebrae. The base was firm and fleshy to the touch, and was covered by subcutaneous tissue and skin apparently of a normal kind. It was raised about three fourths of an inch above the general surface, and was about four inches in diameter.

Means were taken for the protection of the sac from pressure, but despite the

greatest care it ruptured on the third day after birth. The site of the rupture, about one inch long, was near the rounded apex of the now collapsed tumor. The edges of the tear were closely approximated, but between them oozed the cerebro-spinal fluid.

To prevent the escape of the fluid, and at the same time to have a link of connection between the edges of the wound, were the objects aimed at.

The following plan achieved these most successfully :

A piece of ordinary sponge was steeped for a few hours in $\frac{3}{4}$ i. of the ordinary dilute hydrochloric acid of the B. P. From this a thin shaving, about the thickness of half-a-crown, was taken, and its edges trimmed so as exactly to fit the wound. After steeping the sponge in a two-and-a-half-per-cent. solution of carbolic acid, it was inserted between the lips of the wound well into the cavity, the edges of the sponge and the surface of the wound being in the same plane. Over the part was placed a piece of protective silk, all being fixed by adhesive plaster. On the lapse of three days the coverings were removed. Granulations were seen extending into the slice of sponge from each side, and only on minute examination could a trace of fluid be found to be escaping. The part was again covered up as before, and opened once more at the end of a week. It was then found that the granulations had covered in completely the sponge, no part of which was visible, and not a trace of fluid was found escaping. A few days later, examination showed the wound to be entirely healed and covered with healthy-looking epidermis. The child was not again seen for eight or nine months, when it was enjoying good health.—*Glasgow Med. Jour.*, Feb., 1887.

**Pughe (R. N.) on Osseous Anchyl-
losis of the Left Temporo-Maxil-
lary Joint; Resection.**—Geo. S., æt. 6, admitted into the Infirmary for Children, May, 1882. Two years previously he fell on his chin and fractured his jaw, for which he was admitted into hospital for six weeks. After he was discharged his mother said that he could hardly open his mouth, and that his jaws became more and more fixed, so that he soon lost all power of moving. Ever since the accident he has been unable to masticate any solid food. On admission the jaws were found firmly fixed,

and could not be separated even under chloroform and with the help of a gag.

Operation.—An incision was made about $1\frac{1}{2}$ inch along the lower border of the zygoma, and another $\frac{1}{2}$ or $\frac{3}{4}$ of an inch long from its posterior end, a little in front of the ear directly downwards; these were carried down to the bone and the flap turned forwards; the zygoma and the lower maxilla were quite fused together, only a slight sulcus denoting the lower border of the former. I then chiselled through the bone, first at the sulcus mentioned and also $\frac{1}{2}$ of an inch lower down through the ascending ramus. The intervening portion having been removed more or less piecemeal, the jaws were easily separated by means of a gag. The wound suppurated, but healed in about three weeks without much trouble. The boy was put under chloroform every two or three days, and the jaw separated by means of a gag as fully as possible. This was repeated at longer intervals for some months after his discharge. He can now separate his jaws to the extent of two inches, and within that limit the up and down movement is free and perfect. He has, however, none of the backwards and forwards or side-to-side movements.—*Liverpool Med.-Chir. Jour.*, Jan., 1887.

Resection of the Ankle-Joint.—Dumont, in the *Archiv für Klinische Chirurgie*, Bd. xxxiv., Heft 2, 1886, describes the method employed by Kocher, since October, 1883, for performing this operation, and illustrates it by five cases. "The foot is held at right angles to the leg, and an incision is made from the outer edge of the tendo Achillis, curving round and over the point of the external malleolus to the edge of the extensor tendons. The peroneal tendons are now exposed, and each one caught at two points by a ligature and divided between them. The astragalo-crural joint is now opened, the attachments of the ligaments of the astragalus and calcaneum, and the capsular ligament on the anterior and posterior edges of the tibia divided, and the foot is dislocated inward—care being taken not to break off the internal malleolus by using too much force. In this way the whole of the joint is exposed. The diseased tissue is now removed, after which the foot is replaced at right angles to the leg, and the divided tendons are united by sutures. This very important step of Kocher's method is carried out by means of an in-

genious and peculiar form of suture. The ends of a suitable thread are passed by means of two needles into two points at the same level on the natural surface of one end of the divided tendon, and brought out at corresponding points on its cut surface, leaving a loop over a portion of the tendon above. The needles are then introduced into the cut surface of the other end of the divided tendon, and brought out at corresponding points upon its natural surface, drawn firm, and tied. This form of suture is less liable to give way than any other we have seen proposed. The subsequent treatment of Kocher's operation is what is usual in a resection of the ankle-joint." The result in the five cases was admirable.—Editorial: *Med. News*, Jan. 1, 1887. G. B. P.

Shaw (W. J.) on Loose Cartilages in the Knee-Joint.—Under strict antiseptic precautions the author removed twenty-two loose fibro-cartilaginous bodies from the right knee-joint of an iron-moulder.

Twelve months before the operation the patient began first to have pain in the knee, and at the time of operation he had excessive agony night and day from this cause. One month after the operation he was discharged cured.

The smallest body weighed twenty grains, the largest two hundred and thirty; the total weight was one thousand six hundred and eighty-one grains.—*British Med. Jour.*, Dec. 11, 1886. G. B. P.

Bell (James) on a Wound of the Internal Jugular Vein.—The patient while holding a chisel in his hand fell from a ladder, and the chisel was driven deeply into his neck about one inch behind the angle of the jaw on the right side.

The hemorrhage, which was profuse, was at once checked by pressure applied by a fellow-workman. After removal to the hospital, while an examination of the wound was being made, hemorrhage recurred. Pressure on the common carotid checked the bleeding slightly, and this artery was ligated without stopping the hemorrhage. The wound was then packed with three carbolized sponges well dusted with iodoform.

The patient was nearly pulseless, but revived. On the tenth day the wound was redressed and one sponge removed, the second on the twelfth day, and the last at the end of the month.

The patient recovered with a hoarse voice, some difficulty in swallowing, contracture of the sterno-mastoid muscle, and contracted pupil on the right side.

G. B. P.

Pilcher on the Simultaneous Ligation of the Subclavian and Internal Jugular Veins; Ligation of the Axillary Artery.—The patient, a woman, was presented at a meeting of the New York Surgical Society. One and one half years previously, while removing a recurrent carcinoma from the axilla and base of the neck, a slit was torn in both the internal jugular and subclavian veins just previous to their convergence to form the innominate. Ligatures were placed on either side of the rents both in the internal jugular and subclavian veins. Great turgidity of the veins of the upper extremity followed at once, and the axillary artery was then ligated high up. The immediate consequence of the operation was oedema of the arm, coming on within a week and lasting several weeks. When presented the arm was slightly larger than its fellow, but the patient had good use of it.

Dr. Pilcher said he knew of no other case on record where the internal jugular and subclavian veins had been simultaneously ligated. In a Russian journal he had found the report of the simultaneous ligation of the subclavian vein and artery, accidentally cut while an abscess was being opened.—*Med. News*, Dec. 25, 1886.

G. B. P.

Gould (A. P.) on a Wound of the Femoral Vein.—The femoral vein had been accidentally wounded by a knife belonging to a cat's-meat woman. The wound was just below and parallel to Poupart's ligament, and the bleeding was profuse. Mr. Gould enlarged the wound under chloroform, and found that it communicated with the femoral vein, which he ligatured above and below without arresting the hemorrhage. Ligatures were then applied to the internal saphenous and external circumflex veins, when the bleeding ceased. The wound was carefully syringed out with a solution (1 in 2,000) of perchloride of mercury. The femoral artery was seen, and seemed to be quite uninjured. On the following day (October 12th) the patient was comfortable, with normal pulse and temperature. There was no oedema or loss of heat in the damaged limb. In the evening, the temperature

rose to 101.2° F., and on the 13th to 103.6° F., and the patient became restless. On the 17th, there was delirium and a "fit." The wound looked healthy. On the 20th, profuse hemorrhage took place from the femoral artery, which had again to be ligatured. The patient, however, succumbed to the shock and loss of blood on Oct. 22d.—*Brit. Med. Jour.*, Jan. 15, 1887.

Fraucou (A.) on Paraphimosis from the Trapeze.—A youth of seventeen while exercising on the trapeze was seized with a sudden pain in the penis, and on examining it found the foreskin retracted behind the glans. He himself at once, and a doctor a little latter, tried in vain to reduce it.

Reduction was finally accomplished under an anæsthetic.

It seems that, when the young man was exercising, the conversation of some of his comrades standing by excited an erection of the penis on his part. Then in a violent gyration the penis was caught between the bar of the trapeze and the body in such a way as to produce the paraphimosis.—*Lyon Méd.*, Oct. 24, 1886.

Dentu on Suture of the Urethra.—The author does not use the suture in traumatic cases, but always sews up operative wounds of the urethra, particularly if they are in the bulbar or perineal region. Traumatic cases where an operation is required he treats in the same way, *i. e.*, uses the suture.—*La France Méd.*, Nov. 9, 1886.

Gross on Cystotomy in Young Subjects.—Practised on young subjects, suprapubic cystotomy has a mortality of $2\frac{1}{2}$ per cent. Its benignity is due to the favorable anatomical relations of the bladder and neighboring parts in these cases. Healing is facilitated by the infrequency of decomposition of the urine in children. The sutures should be of silk, and the abdominal wound should be left open. The catheter should be used whenever needed, but not left in.—*La France Méd.*, Oct. 28, 1886.

Dozier (B.) on Castration.—It goes without contradiction that one who inherits, as well as one who is afflicted with lunacy, should not marry. The sins, or rather the afflictions, of the parent, in this disorder particularly, are almost certain to be visited upon the children, even unto the third and fourth generation.

But there is no law to prohibit any one

who inherits the disease, or who has himself been a lunatic, from marrying. The lunatic at least, therefore, should be castrated on general principles, not only as a precaution against future attacks in himself, but also as a protection to future generations.

A medical board consisting of the resident physicians of the asylum, and two or more consulting physicians, should be a part of every lunatic asylum, and whenever, in the opinion of this board, the operation of oophorectomy or castration would be of benefit to any inmate of the asylum, the operation should be performed.

I believe that the time is not far distant when this operation will be a common one for the cure of certain classes of lunacy and epilepsy.

I believe it should also be a part of the penal law of our land, that when a person has been proven guilty of rape, he should, in addition to being compelled to serve a term of years in the penitentiary, also be castrated, when the death penalty is not inflicted.—*Pacif. Med. and Surg. Jour. and West. Lancet*, Feb., 1887.

Hall (W. H.) on Fractures in a Cancerous Patient.—On the 13th of May, 1885, I was called to see Mrs. O., fifty-two years old. On the preceding Saturday (the 9th) she rose from her chair to cross the room, when her right leg gave way, and she fell to the floor. She was placed on the bed and a legally qualified physician was sent for, who pronounced it a case of rheumatism, left some linament, and advised her to be taken to his institute (?), where he could cure her for one hundred and fifty dollars. When I first saw her, she had suffered for about eight months with more or less pain in the right thigh, with some swelling. I found the patient in bed on her back, with shoulders elevated, right knee lying over the other thigh, flexed, with foot inverted, the thigh forming an obtuse angle, the apex of angle at about its middle third. She was suffering acute pain, and was extremely nervous. I gave an opiate, and decided to call the next morning with assistants, administer ether, and make a thorough examination. On the 19th, a mixed anæsthetic of ether, chloroform, and alcohol was given; the patient went under its influence kindly. Fracture of the femur was found as above, with evidently disease of the bone. It was difficult to decide how

the limb should be dressed, from the fact that the patient had a vesico-vaginal fistula, as a result of an operation for stone some years previous. The inside of the thighs were excoriated from the constant dribbling of urine, particularly the injured thigh. The patient suffered from asthma, so that she could not take the recumbent position, and she had extensive cancerous disease of the left breast, in a state of extensive ulceration. The limb was put up in plaster bandage, with strips of willow splint around the thigh, and inside of same protected by patent lint smeared with vaseline; foot of bed raised and extension made by weight. It was impossible to keep the patient in any one position for any length of time; the constant escape of urine saturated the dressings, ulcers formed underneath, and appliances had to be removed to relieve pressure; extension and counter-extension were kept up as well as possible. Another fracture occurred in removing the patient to a fracture-bed, and still another afterwards in placing her on bed-pan. She finally succumbed to the complication of troubles on the 18th of September. The femur of injured limb was removed entire the next day; the bone was in four pieces, showing no attempt at union. The finger nail could easily indent the bone nearly its whole length. After the flesh had been removed by boiling, the middle piece could be almost powdered between the thumb and finger. The weight of the whole femur was four and one quarter ounces, in contrast with fourteen ounces for a healthy one of about the same size. There had been in the patient's family some three or four cases of cancer.—*Albany Med. Annals*, Jan., 1887.

Harrison (E.) on Scald of the Larynx; Tracheotomy; Recovery.—Charles C., aged two years and four months, was admitted on January 2, 1886, at 6.30 P.M. At 2.30 P.M., on the day of admission he attempted to drink from the spout of a kettle containing boiling water.

On admission, there was some cyanosis and sucking in of the lower ribs during inspiration. He was at once put into a tracheotomy cot, with a steam kettle, in a warm room. At 8 P.M. the symptoms were much relieved. At 9 P.M. he became much worse; there was much cyanosis and sucking in of the chest-walls during inspiration, and the breathing was stridulous. Trache-

otomy was performed, and at once relieved him.

On the following morning the temperature was 103.4° F. This came down gradually day by day. For the first few days there was much bronchial discharge, so that the tube had to be cleared with a feather every five minutes. His pulse was 150, and respiration 60 to 80. The patient then began to improve, and on the twenty-third day the tube was removed.—*The Lancet*, Dec. 18, 1886. G. B. P.

Weiss on Sublingual Abscess—Tracheotomy.—A sublingual abscess followed a periostitis of a wisdom tooth. Symptoms of asphyxia called for tracheotomy, and artificial respiration had to be kept up for a half hour. Later there was an osteo-periostitis of the inferior maxilla and a subhyoidian abscess. Both were operated upon.

The asphyxia the author did not attribute to œdema of the glottis, but to the crowding back of the tongue.—*La France Méd.*, Jan. 29, 1887.

Harrison (Edward) on Intestinal Obstruction Cured by Inversion and Injection of Air.—Frederick F., aged four, was admitted on Jan. 24th. The child was well and the bowels acted regularly daily until Jan. 15th, when they did not act. Vomiting began the same evening and continued until the day of admission, when it had become very offensive. No blood or mucus was passed. The child complained of abdominal pain, and refused to take any food.

On admission the face was flushed and looked pinched, and he was much emaciated. Abdomen distended; pain referred to umbilicus. Tongue red and dry; pulse small and frequent. He vomited once, but the vomit could not be collected; it smelt, however, stercoraceous. Under chloroform the abdomen was found to be distended and tympanitic all over; no sausage-shaped tumor to be felt. Per rectum a few scybala were removed from its lower part, and a mass was then felt which seemed to be scybala covered with mucous membrane. The child was then inverted and air pumped into the bowel: this could be felt entering by the hand placed on the abdomen. After a short time the air seemed to enter more easily, judging by the force required to squeeze the syringe. The inflation was then discontinued and the finger again introduced into the rectum, where

the fold of mucous membrane had disappeared, and some free scybala were found and removed. The finger could now be passed above the brim of the pelvis, where more scybala were lodged. An enema of a pint of warm water was then injected, which brought away some hard lumps, but no blood or mucus. The abdomen was rubbed with an oiled hand, which assisted in expelling the water and a small formed motion. Three minims of tincture of belladonna and three of tincture of opium were given in a teaspoonful of water, but were immediately vomited; the vomit was stercoraceous. A twelfth of a grain of morphia and of belladonna was introduced as a suppository, and the child passed a good night.—*The Lancet*, Dec. 18, 1886. G. B. P.

Glover (E. E.) on the Treatment of Anal Fistula Associated with Phthisis.—Operative interference is advised and practised with benefit to the patient, excepting, 1st, where the cough is constant, unless this be first allayed; 2d, where the pulmonary disease is either rapidly advancing, or is far advanced; 3d, where the reparative powers of the patient are so low that they evidently are unequal to the task of healing the wound.

Although it is proper to operate during any season, preference should be given to pleasant weather, such as will allow the patient to be in the open air.

Where the tissue surrounding the fistulous tract is supposed to be tubercular, some advise its removal by the knife or sharp spoon.

The wounds heal in nearly every case in which an operation is justifiable. There should be as little interference with the sphincter muscles as possible.

The suppression of the discharge is thought to be positively beneficial.

It is recommended by some that where the discharge is supposed to have a beneficial derivative effect, a seton be inserted in the arm or other eligible part, before operating on the fistula.

It is believed that a successful operation tends to retard the progress of the disease, and to prolong the life of the patient.—*Jour. Am. Med. Ass'n*, Nov. 20, 1886.

Simonton (A. C.) on an Incorrect Wood-Cut in Gray's Anatomy.—I have before me the tenth edition of "Gray's Anatomy," opened at page 925, on which page is a plate representing a view from

within the pelvis. This cut is given to illustrate the anatomy of hernia, and especially the relation of certain blood-vessels to the hernia openings. Let the reader now turn to this cut in his "Gray," *no matter what edition*, although the page may not be the same as the one given. In looking at the cut it will be observed that the large artery and vein are designated: "Femoral Artery," "Femoral Vein." These names are printed on the vessels. The names are incorrect at this point on these vessels. The artery is the *external iliac*, the vein the *external iliac vein*. The names femoral artery and femoral vein are not given to these vessels until they pass beneath Poupart's ligament. This plate serves to confuse the student in his studies of hernia.

It will be noticed that the deep epigastric artery is represented as originating from the femoral, so-called, just above Poupart's ligament. The point of origin of said artery is correctly given, but is from the external iliac and not the femoral. Correct the names of the large blood-vessels mentioned and confusion will disappear. I am surprised to find this same wood-cut reproduced in "Stimson's Operative Surgery."—*Jour. Am. Med. Ass'n*, Feb. 5, 1887.

DISEASES OF THE EAR AND EYE.

Buck (A. H.) on Chronic Catarrhal Inflammation of the Middle Ear.—Let us overhaul our stock of knowledge in regard to this very common aural affection, and see what our possessions are, and how they compare with what we possessed a few years ago.

First, with regard to the nature and characteristics of the affection. Are our conceptions more clearly defined than they were fifteen years ago? It cannot be said that they are. Local conditions or lesions of the middle ear, entirely independent of any thing worthy the name of catarrhal disease, are doubtless, at times, still mistaken by all of us for the latter affection. As all are familiar with the symptomatology, this part of the subject is dismissed. Our conceptions of the pathology of the disease are, in one respect, appreciably in advance of those held twenty years ago. I refer to the relative importance assigned to the two seats of the catarrhal disease, viz., the Eustachian tube and middle ear on

the one hand, and the vault of the pharynx on the other. At the earlier date almost all our therapeutic energy was expended on the Eustachian tube and middle ear. At the present time there are few, I imagine, who do not look on the pharyngeal centre as by far the more important of the two. I believe that, in a large proportion of the cases, treatment directed to the vault of the pharynx is all that is required in the way of local interference. We come next to the causes of this disease. So far as the intrinsic causes are concerned, we still possess only very few facts, and these often contradictory; in some the tendency to catarrhal inflammation appears to have been handed down from parents to children. Just as often, however, we fail to trace out any such influence. We have, I believe, gained clearer conceptions of the factors which promote a continuance of the catarrhal process. Not only do we appreciate thoroughly how cold may disturb the delicate balance maintained between the functional activity of the skin and the state of the blood-vessels and glandular structures of the pharyngeal mucous membrane, but we have learned that there is a form named *gouty*, or *lithæmic*, throat as well. The importance of this discovery will appear when we take up the subject of treatment. Then, through clinical observations and therapeutic studies, we have discovered that obstruction of one nasal passage—when associated with hypertrophied mucous membrane of the vault of the pharynx in the median line—produces much the same mechanical effects upon the drum cavity of the corresponding side, and its contents, as does an obstructed Eustachian tube. The mechanism of action, however, is different. Each act of swallowing means the exhaustion of the air in the vault of the pharynx. In a normal condition of the nasal passages air enters freely to fill the vacuum. But let the nasal and naso-pharyngeal obstructions so exist that air cannot rush in, then a suction force will immediately be exerted upon the air in the tympanic system of cavities. The results are two: there will be, for a short time, greatly diminished atmospheric pressure upon the mucous membrane of the middle ear on the one hand, and greatly increased atmospheric pressure on the outer surface on the other. Imagine this state of things to be repeated scores of times every day, and it will be an easy

matter to understand how injurious the effects may be on the apparatus of hearing. Among the minor exciting causes may be mentioned tobacco-smoking, which is better understood to-day than in former years. It is not probable that the burning paper, as in cigarettes, is more irritating than is that of the tobacco-plant alone. Climatic influences have always been considered as active agents in promoting or restraining chronic catarrhal affections of the middle ear; but I am not aware that we have yet learned how to differentiate.

In former years it was common to use woollen and fur wraps about the throat during the winter season. This is now greatly diminished, owing to protests of sensible medical advice. Another way of keeping alive a catarrhal tendency, is the American craze for fresh air, manifested in the habit of sleeping with open windows, or due to those fresh-air fiends who make our railroad cars, club-rooms, etc., nurseries of pneumonia. Finally, there is another exciting cause which I believe to be more common than generally supposed. I refer to retained and inspissated secretion in the crypts of the tonsils. A slender ring-shaped curette of steel with rounded edges answers the purpose of exploring and removing these badly smelling cheesy masses. The improvement which follows the removal and washing out with listerine and water (1 to 3 or 4) is generally marked. We come now to treatment. And the antecedent history is always of value. In the case of smokers it is not necessary to interdict altogether; a single cigar may often be permissible in the twenty-four hours. The habit of sleeping with open windows should be promptly checked. In the *gouty* or *lithæmic* cases, local applications make little or no impression. The proper method is careful regulation of diet and exercise, especially the latter. Exercise to the amount of four miles' walk per day should be insisted upon and in the open air. Warm baths at night. Use of laxatives every alternate day. In local treatment finely divided sprays are the best, though I give the preference to cotton holders. Of remedies, nitrate of silver and tincture of iodine hold the first place.

A. T. M.

Miot on the Treatment of Purulent Otitis Media.—As caustics, Miot uses nitrate of silver, chromic and carbolic acid, often the galvano-cautery. The medicinal

powders which appear to be efficacious are boric acid, iodoform, and sulpho-carbolate of zinc, either alone or combined with sugar or calcined magnesia. Local blood-letting even of small amount calms the pain.

Hot applications upon the ear and its surrounding parts are particularly indicated when a discharge has been suddenly stopped either by cold or strong astringent applications. Blisters on the mastoid region are of service when there is a fetid discharge with granulations in the canal. Iodine or the cautery on the same region do good, particularly in children.

In this disease the author considers local treatment of prime importance, and considers most cases easily curable.—*Bull. gén de Thér.*, Jan. 15, 1887.

Bishop (S. S.) on Novel Methods of Treating Diseases of the Middle Ear.—One of these methods consists in the reverse of the Valsalvian experiment. The patient closes the mouth and nostrils, and exhausts the air in the naso-pharynx by a strong inspiratory act. This causes the suction of the column of air and the secretions from the Eustachian tube and tympanum into the pharynx. The success of this practice is apparent in several ways. First, the subjective sound of rushing air followed by the sensation of a movement inward of the drum-head. After the discharge has entered the throat it may be seen on inspection, either with or without the rhinoscopic mirror. Sometimes after spitting out the discharge a peculiar, disagreeable, metallic taste is left. After removing the discharge the Valsalvian or Politzer methods are practiced to restore the equilibrium of atmospheric pressure. Inflation should not be done too quickly afterwards, otherwise the entrance of air may force some remaining fluids back into the tympanic cavity. The discharge is not from the nasal cavities, as it occurs when there is no naso-pharyngeal catarrh. There are cases in which this method is impracticable, as when the walls of the tube are so swollen as to occlude it, or occupied by gelatinous adhesive secretions. Yet after an ineffectual attempt, success has often rewarded repeated efforts. When a short spasmodic effort does not suffice, an inspiratory act prolonged for five or ten seconds may succeed. Another way of applying this method is by means of a syringe fitted to a Eustachian catheter *in*

situ; gentle traction then being applied to suck out the secretions. Care must be taken in placing the catheter, as otherwise part of the impinging mouth of the Eustachian canal will be drawn in, preventing the fluids from escaping, and occasioning some irritation. A Politzer air-bag without a valve may be substituted for the syringe. Finally, a third method is described by which medicinal solutions may be applied to the mucous tract of the ear, in those cases where pus is discharging through a perforation of the drum-head into the external meatus. After cleansing the external canal, the patient's head is inclined to the opposite shoulder, the medicated fluid is dropped in, and the patient is then instructed to practise the first method—that is, the act of inspiration with nose and mouth closed.—*Jour. Am. Med. Ass'n.*

A. T. M.

Powers (G. H.) on Tobacco Amblyopia.—In an interesting communication on this subject the author states that for years he has used amyl nitrite in all cases of amblyopia for assistance in diagnosis. For he has proved that in progressive atrophy from other causes no benefit is derived from the exhibition of the amyl, while in tobacco amblyopia vision is immediately and markedly improved. A patient presenting the ordinary signs of incipient atrophy with evident diminution of circulation $FV = \frac{2}{3} D$ or $\frac{2}{3} \frac{0}{0}$. Inhalation of a few drops of amyl, pushed only to the point of lively hyperæmia of the face, and headache will cause increased circulation in disc and retina, and in five minutes or so $V = \frac{1}{2}$ or $\frac{2}{3}$. This shows that V is not entirely lost. This improvement is only temporary, as within an hour or two $V = \frac{2}{3}$ or $\frac{1}{2} \frac{0}{0}$, when daily inhalations with general tonic treatment and avoidance of tobacco and alcohol will do much. He remarks that as the only action of the amyl seems to be to increase the blood supply, it would seem that tobacco amblyopia is due simply to a loss of function from anæmia, which may result in atrophy if long continued.—*Provincial Med. Jour.*, Feb. 1, 1887.

A. T. M.

Critchett (A.) on Dislocation of the Lens.—This accident, though not of extreme rarity, is yet sufficiently uncommon to justify ophthalmic surgeons in placing their experiences of it on record.

First is that of a young barrister, aged twenty-four, who was highly myopic, and

who some ten years previously had, while practising gymnastics, dislocated the lens in his right eye.

An attempt was made to remove it, but the operation was not successful. The patient, by cautious use of the remaining eye, was able to complete his education both at school and college, and was careful to avoid any sudden or violent physical exertion; but a few days before I first saw him in September, 1884, he had, whilst fishing, been tempted to jump suddenly off a bank to secure a particularly fine specimen of the finny tribe, and at the same moment he felt that something had given away in his left eye. I saw him four days after the accident, and found the lens had become dislocated forwards into the anterior chamber. The patient could still read Jaeger 2, but the tension had increased, and after a consultation with Sir William Bowman it was decided that the lens must be removed.

When the patient had been placed under the influence of an anæsthetic, I passed a fine needle through the substance of the lens, and it was held there by my colleague, Mr. Juler, while I proceeded to make the necessary section.

This latter was not very easy to accomplish, because the lens occupied the whole of the anterior chamber, but I used a very narrow Graefe's knife, and completed the latter half of the section by a series of small cuts, after the manner of the late Mr. Streatfeild.

I did not attempt to perform iridectomy, but at once inserted a spoon beneath the lens and extracted it, Mr. Juler withdrawing the fine needle as soon as my traction instrument was *in situ*. Very little vitreous was lost, the edges of the wound were seen to be in apposition, and the lids of both eyes were kept closed with small strips of plaster. These latter were applied for more than a fortnight, and I did not suffer the eyes to be open for eighteen days, when I was pleased to find that perfect union had taken place, and a few weeks later the patient was able, with suitable lenses, to see $\frac{5}{6}$ and read Jager 1.

The second case was that of a young gentleman, aged seventeen, who was brought to me by Mr. Sydenham Knott.

Whilst he was amusing himself with chopping wood, a log flew up and struck him violently on the right eye. When I first saw him there was a little blood in the

anterior chamber, and the lens was seen to be dislocated backwards.

A corneal section upwards was made. As the upper edge of the lens was depressed backwards, some difficulty was experienced in passing a spoon beneath it, but by introducing the latter at the outer angle of the section, and sliding it under from the outer side, I succeeded in extracting the lens. There was a considerable loss of vitreous, but the lids were supported by strips of plaster, as in the first case, and the patient made an excellent recovery, but there is a large atrophic patch near the macula, and, although the hands of a watch can be seen eccentrically, the sight will remain very imperfect.

In the third case, a gentleman, aged twenty-nine, received a severe blow on his left eye from a cricket-ball, which dislocated the lens outwards and slightly upwards, so that it was evidently hinged upon its lower margin, because, whilst the eye was under ophthalmoscopic examination, the lens would suddenly fall downwards into something like its natural position, and then a few moments later a slight movement on the part of the patient would throw it again into its new resting-place.

Soon after I first saw the injured eye it became so rapidly hard that I felt that an attempt must be made to extract the lens, and this opinion was confirmed by Sir William Bowman.

Ether was administered, and I made an incision with a very broad keratome at the inner side of the cornea, and there was an immediate gush of vitreous, but I at once passed a Taylor's vectis in the direction in which I hoped to find the lens, and as I withdrew the instrument I was delighted to find that I had secured the object of my search. Plaster was applied over the lids, as in the former cases; the patient made a slow but good recovery, and with the aid of a lens can see the time by a watch correctly. In future I shall be inclined to use the vectis for removing dislocated lenses in preference to the spoon, because the former allows the lower portion of the soft lens to sink through the aperture in the wire loop, and there is less chance for the lens to slip away during the process of extraction.—*British Med. Jour.*, Jan. 15, 1887.

A. T. M.

Dale (F.) on a New Style for Facilitating the Treatment of Stricture of the Lachrymal Duct.—The many

difficulties in the way of satisfactorily treating obstinate cases of this apparently simple affection have induced me to devise grooved styles of various sizes, made of silver-gilt, and each arranged to slide along Bowman's bulb-ended lachrymal probes. They are so constructed that the probe and its corresponding style will together pass through an opening which will not admit the next-sized probe. In performing the operation, as soon as the canaliculus has been slit up and a probe inserted, a style of corresponding number can be gently pushed along the probe through the stricture. The probe is then withdrawn, leaving the style in position. After a few days' interval the probe may again be passed along the grooved style, and the small style replaced by a larger one. This process may be repeated until as large a style as may be wished has been inserted. This may then be left in the dilated stricture. In case of irritation produced by the presence of the style, it may be withdrawn and replaced in a similar manner as before when the irritation has subsided. The cases in which these grooved styles will be found most useful are: (1) Very tight or almost impermeable strictures. (2) Strictures complicated with fistulous openings and displacement of the natural passages. (3) Strictures in children or very nervous subjects. The advantages claimed by using these instruments are: (a) Greater facility of introduction. (b) It is more advantageous where rapid dilatation is required. (c) There is a more perfect system of drainage, of natural as well as of inflammatory secretions. In those cases in which I have had an opportunity of putting the instruments to a practical test the result has fully realized the expectation formed of them, and I venture to think that their use in dealing with almost intractable cases will be attended with much benefit.—*London Lancet*, Jan. 1, 1887.

A. T. M.

Gilmore (A. P.) on a Case of Acute Irido-Cyclitis with Persistent Increased Tension Successfully Treated by "Badall's" Operation.—Mr. J. R., aged thirty-five, presented himself, suffering from a severe attack of what seemed to be idiopathic irido-cyclitis of the left eye. He had never had sore eyes before. There was considerable pericorneal injection, pain over the ciliary body, augmented tension, severe pain, annoying

lachrymation, photophobia, and blepharospasm. The usual treatment was adopted, atropine alternating with eserine and massage, leeches, hot water, and anodynes. The eye did not improve, the pain grew worse, and the tension increased. As he had suffered with syphilis ten years ago, he was placed on anti-syphilitic treatment, but with no relief. Opiates were given at night to produce sleep. This treatment was continued three weeks, with only occasional relief, followed by renewed exacerbations.

I suggested to him, with some reserve, Badall's operation, to which he readily consented, and the operation was performed without an anæsthetic. The result was most gratifying; the pain subsided, the tension diminished, and the patient slept that night without narcotics.

The next day both subjective and objective symptoms were much improved. I discontinued all other treatment excepting the atropine, which was continued for four days after the operation. On the tenth day the patient was discharged cured, with normal vision. He was seen again on December 1st, and states that his eye has been perfectly well since the operation.

"Badall's" operation consists in neurectomy of the nasal branch of the trigeminal nerve, and is employed by the originator for persistent and painful increased tension in glaucoma. The results of the operation are due to reflex action on the eye through the branches of the fifth nerve. The operation has been indorsed by Abadie in his observations on glaucoma, and adds one more to the class of anti-tonic operations, such as sclerotomy, iridectomy, paracentesis, etc.—*N. Y. Med. Record*, Jan. 29, 1887.

A. T. M.

Dor (H.) on Recovery from Congenital Blindness.—A few days after birth the patient was seized with a purulent ophthalmia which nearly destroyed both eyes. When two years old, the girl was declared hopelessly blind. When twenty-two years old she presented herself to Dr. Dor, with an atrophied and entirely useless right eye, and with a large leucoma occupying the central and lower parts of the left cornea. The upper and inner part of the left cornea was transparent, and through it the blue iris was seen to be adherent to the leucoma. The pupil was completely obstructed, but the patient had some per-

ception of light, and could distinguish large shadows. Dor performed iridectomy at the inner margin of the iris. In a few days the patient began to learn things by sight, and in a little over a month she could read coarse print. The resulting pupil was very good, but the eye was in such a state of nystagmus that a good view of the fundus could not be obtained. Some slight opacity of media was made out.

At the time of writing the article the patient was reported to have sufficiently acute vision to act as organist.—*Lyon Méd.*, Jan. 30, 1887.

PATHOLOGY.

Prudden (T. M.) on Mycotic or Malignant Ulcerative Endocarditis.—Bacteria are frequent in a certain proportion of cases of acute ulcerative endocarditis in the cardiac, and, when these exist, in the peripheral lesions. These bacteria are small and of spheroidal form in almost all of the cases thus far described; but in a few cases the presence of bacilli has been noted. There are cases of ulcerative endocarditis with extensive destruction of tissue and large formation of thrombi, in which the lesions are entirely free from bacteria. In these cases, as a rule, the endocardium is the seat of an old inflammatory process and the peripheral embolisms, infarctions, etc., do not contain bacteria.

In many cases of acute ulcerative endocarditis associated with bacteria the valves and endocardium are also the seat of old inflammation.

The destructive process and formation of thrombi in the heart valve and endocardium may be as marked and extensive in the cases in which the bacteria are absent as in those in which they are present; but in the latter class of cases the embolic lesions which are apt to be developed are of an infectious nature, and the general course of the disease is apt to bear the stamp of an acute infectious disorder.

These two classes of cases may be appropriately designated as *ulcerative* or *acute ulcerative endocarditis*, but those in which the bacteria are present should be distinguished by the term *malignant bacterial* or *mycotic ulcerative endocarditis*.

The gross appearance of the valvular

lesion does not always or usually enable us to distinguish between these two forms of disease. Bacteria are sometimes present in cases of acute vegetative endocarditis, but in the lesions of chronic proliferative endocarditis they do not appear to occur at all.

The bacteria which are present in the cardiac and peripheral lesions in cases of malignant ulcerative endocarditis are the causative factors in the disease. This has been shown by three independent observers, who have isolated the same species of bacteria from cases of this disease in man; obtained them in quantity in pure cultures; induced in rabbits by their inoculation, under special conditions, lesions of the endocardium as nearly identical with those in man as the nature of animal experimentation will permit; and finally determined the presence of the same bacteria in the cardiac and peripheral lesions of the operated animals.

The bacteria apparently produce the cardiac lesions by lodgment on the surface of the valves and endocardium, when the latter are rendered vulnerable to their action either by mechanical or chemical injury; or by the presence of old inflammatory alterations; or by conditions unknown to us.

Bacterial embolism of blood-vessels of the heart valves is apparently not of frequent occurrence, as was formerly believed.

The only bacteria which have been thus far absolutely identified as occurring in the lesions of malignant ulcerative endocarditis in man are streptococcus pyogenes and staphylococcus pyogenes aureus. This identification has been made in six cases.

It has been demonstrated that other species of bacteria than those above mentioned are capable of causing similar lesions in rabbits under similar experimental conditions.—*Am. Jour. Med. Sci.*, Jan., 1887.

Hérard on Syphilitic Infection by the Nipple in a Man.—A man of sixty-three had irregular sexual relations with a woman. In eight or ten days the man began to have pain in the nipple, which became hard. Three weeks after infection there developed a small sore with grayish surface and hardened edges, located at the base of the nipple. A few days later induration had invaded the entire base of the

nipple, while the entire neighborhood had an erysipelatous look, and a lymphatic gland in the axilla of the same side was enlarged. There was no lesion on the penis.

A little less than two months after the infection a roseola and later a confluent papulo-squamous eruption appeared.—*Ann. de Dermat. et de Syph.*, Jan. 25, 1887.

On Chancre of the Tonsil.—C. Bœck¹ narrates three cases of chancre of the tonsil. In one case the patient was a girl of nineteen, the only probable mode of contagion being some children with hereditary syphilis. Another was a girl of fourteen, and the third a woman of twenty-four. The author had seen nine cases of tonsillar chancre in ten years, which led him to suppose the lesion more common than usually supposed. He considered the common mode of infection in these cases was through the use of infected eating and drinking utensils. The surest diagnostic sign is enlargement of the lymphatic behind the jaw. The appearance of secondary symptoms, of course, helps in the diagnosis. The author advises the use of atropia during the eruptive stage.

A Graarud² reports three similar cases in the same family. The first case was a man of twenty-four, the second a woman of thirty-five, his sister, and the third a man of eighty, their father. Contagion in these cases was by using the same cups and pipes.—*Rev. Mens. de Laryng., d'Otologie, et de Rhinologie*, Jan., 1887.

Pasteur on Syphiloma of the Heart.—The post-mortem was on the body of a woman who was brought in dead. The wall of the left ventricle and the septum ventriculorum were thickly studded with opaque yellowish-gray patches of varying size. The endocardium was implicated in several places. There was a similar but less extensive affection of the right ventricle. Under the microscope the morbid process was seen to be an actively infiltrating corpuscular growth, very vascular near its spreading margin. Some of the vessels showed well-marked peri-arteritis. The central portions of the disease showed an early degree of degenerative change. There were no signs of fibrillation or fibrosis. The muscular tissue was undergoing atrophy without degeneration. The liver was slightly enlarged, and sections showed

areas of diffuse interstitial cirrhosis in a very early stage, in addition to slight general fatty change. Chiefly by a process of exclusion the writer arrived at the diagnosis of diffuse syphiloma. A somewhat similar case in a boy of twelve, of syphilitic parentage and aspect, was referred to. It was suggested that chronic alcoholism might be a factor in the case.—*Prov. Med. Jour.*, Feb. 1, 1887.

Purser on a Liver with Two Gall-Bladders.—The specimen was taken from a girl, aged eleven years, who was admitted extremely ill of scarlatina, and who died a few hours after her admission. At the post-mortem on dissecting off the serous coat of the liver, two separate gall-bladders were found, each of which had a distinct cystic duct; and these opened into the bile duct, the one at some distance from the other. There were no marked anomalies in the liver, except that the common hepatic duct, instead of dividing into two branches when coming into the liver, divided into three—one to the left, another to the right, and a third running into a posterior part of the liver. These ducts did not communicate with one another, but were distinct in their whole course.

A similar case is reported by Foot in the "Philosophical Transactions" for the year 1693-94.—*Dublin Four. Med. Sci.*, Jan., 1887.

Wiglesworth (J.) on Primary Cancer of Gall-Bladder.—The patient was a woman of sixty-eight. The gall-bladder was converted into a solid mass of new growth, of irregularly pyriform outline, measuring four inches by one and a half inches. Yellowish-white on section, and of tolerably firm consistence. At the larger end is a cavity, about the size of a small-shelled walnut, in which a single faceted gall-stone rests; this is of squarish outline, and about the size of a marble. This cavity is all that remains of the cavity of the gall-bladder. There are traces of a bile-stained dilated duct at the smaller end of the tumor. The duodenum and head of pancreas were firmly adherent to the under surface of the tumor, but not incorporated with it. The upper surface was firmly in contact with the under surface of the liver, and the new growth had here infiltrated this for a depth of about an inch and a half; there were also secondary nodules sparsely scattered through the

¹ *Tidskrift for praktisk Medicin*, Oct. 15, 1885.

² *Rev. Inter. des Sci. Médic.*, No. 32, 1886.

liver. Secondary nodules also in left lung, intestines, and mesenteric and retroperitoneal glands. — *Liverpool Med.-Chir. Jour.*, Jan., 1887.

Shershevski (M. M.) on Mobility of the Heart.—The author publishes in the *Vrach* a paper on the mobility or displacability of the heart. He gives details of the examination of forty persons, all of them free from cardiac and pulmonary affections, in whom he noted accurately the position of the heart's boundaries in the upright dorsal, left lateral, and right lateral positions. The chief mobility was towards the left side, but the heart was often quite perceptibly displaced to the right, as well as downwards and even backwards. The chief conditions under which this occurred were youth, nervous states, and freedom of the vessels from signs of sclerosis. Displacement backwards was found in nearly half the cases, and this shows that the heart ought to be examined in the upright posture. The writer specially remarks on this when the examination is made as a prelude to the administration of chloroform, whereas, as a rule, the stethoscope is applied when the patient is lying down and in a very agitated frame of mind, which latter condition always renders the organ more easily displaced; and the diminished diameter due to this may lead to erroneous conclusions if the measurements be not previously taken in an upright position. This has reference chiefly to young persons. In the case of subjects over sixty years of age, and of much younger persons whose arterial system had already begun to show signs of degeneration, there was little or no displacement produced in any position. — *Lancet*, Nov. 20, 1886.

Blaine (M. D.) on Bovine Tuberculosis, etc.—From his observations of tuberculosis the author has formed the following ætiological conclusions:

1. In the bovine species, the disease is inherited either from male or female.
2. Tuberculosis is acquired by the inhalation of tuberculous substances.
3. Tuberculosis is acquired by the ingestion of milk of tuberculous cows, when the disease has reached the stage of suppuration, or when there is a tuberculous affection of the milk-bag.
4. The disease may also be acquired by the ingestion of the flesh of tuberculous animals. — *N. Y. Med. Record*, Jan. 15, 1887.

The Bacillus of Typhoid Fever.—An inquiry lately made by Dr. Brouardel into the circumstances of an outbreak of typhoid fever at Compiègne led to the discovery of a bacillus in the water which the victims used for drinking. This is the well-known bacillus which, when cultivated in gelatine, multiplies in colonies; and a similar germ was found in blood drawn from patient suffering from enteric fever. It had probably come from the water-closets, which were established in a sandy, porous soil; beneath this was a layer of compact clay, through which the water drained to the well. The bacilli were much more numerous in the infiltrations of the sandy layer, a purification apparently taking place there which left the well-water limpid, without any impure taste. This fact proves that in the filtration of sewage-water through the soil, certain organic matters may be retained, whilst dangerous bodies are allowed to pass. — *Br. Med. Jour.*, Jan. 22, 1887.

Sewill (H.) on the Density of the Teeth as Influenced by the Food, etc.—It is hardly possible to imagine the occurrence of degenerative or nutritive changes in a tissue like enamel—the tissues in which caries begins. To believe in such changes we must first conceive of some means by which this calcareous substance, as dense as quartz and devoid of cellular elements, could assimilate nutritive material when conveyed to it; and we must next imagine the conveyance of new and effete material to and from the vessels of the pulp, through the odontoblast layer of the pulp, and through the dentinal fibrils to its destination in the enamel. The evidence is overwhelming that dental caries is due entirely to external agents; that enamel and dentine are perfectly passive under the process of disintegration; manifesting neither pathological action nor vital reaction of any kind. A dead tooth placed in the mouth as an artificial substitute is just as liable to caries as its living neighbors; when it is attacked decay begins in those situations where it would be most liable to disease were it living, and the decay is true dental caries, identical in every way with the disease in living teeth. There exist three demonstrated predisposing causes of caries which enable us to understand clearly its common association with diseases and cachexiæ: 1st, innate structural imper-

fections in the tissues—from which few sets of teeth are free,—varying infinitely in different individuals; 2dly, crowding and irregularity of the teeth, equally varying in degree; and 3dly, vitiation of the secretions of the mouth, not only varying in amount, but highly irregular in its appearance and duration through the life of different individuals.—*Lancet*, Jan. 1, 1887.

Bruen (E. T.) on Primary Sarcoma in the Anterior Mediastinum.—The clinical features peculiar to this case, although by no means unique, yet deserve consideration:

1st. The morbid growths in this region of the body are usually sarcomatous.

2d. The age of the patient, which was seventy, is unusual yet recorded in tumors of a sarcomatous nature in this location.

3d. The absence of wasting and cachexia. The patient's appearance was that of a person in average health. This peculiarity is also not remarkably exceptional in this class of cases.

4th. The almost entire absence of any subjective symptoms pointing to the morbid growth. The patient was under observation but a few days before her death. She complained of slight cough and dyspnoea, and auscultation of the chest revealed feeble respiration over the posterior portions of both lungs, also anteriorly over the left apex.

There was dulness on percussion over the sternum, and some four finger-breadths to the left of the sternal margin; but when these physical signs were detected the patient was near her death, and their true significance was not established.

The patient came to the hospital for treatment of symptoms which were plainly dependent upon renal disease, such as albumen with casts in the urine; increased arterial tension; with nervous symptoms usual to uræmia, which was the immediate cause of death. As the patient had worked as a domestic until shortly before applying to the hospital, it is fair to assume that there were no important subjective symptoms to call attention to the thoracic mischief.

5th. The foregoing statement is in consonance with the history of anterior mediastinal growths, which are much less likely to occasion severe pressure symptoms than tumors originating in the other mediastinal regions.

6th. While the diagnosis in this case was not established during life, the dulness over the left sternal region, the distant and feeble heart sounds, and weak respiratory murmur over the left apex with the dyspnoea were certainly suggestive symptoms.—*Med. News*, Feb. 12, 1887.

Grauer (F.) on the Pathological Anatomy of Scarlatinal Nephritis.—

The author described his own researches, based upon nine cases of glomerulonephritis. The kidneys were enlarged and hyperæmic. There was no loss of cortical striæ, and in some cases the cortex might be somewhat thickened. The glomeruli were pale, prominent, and more or less enlarged.

As regards the microscopical examination, the uriniferous tubules were apparently normal. There might be some evidence of a slight parenchymatous inflammation, and the epithelium might be somewhat swollen, while occasionally a cast in the tubules could be seen. The glomeruli were bloodless. Very rarely, a red blood-corpuscle could be found in the lumen of a capillary. When examined with a low power, the glomeruli were found larger than normal, and covered with a mass of nuclei. With an immersion-lens, the following changes could be noticed in the capillaries: In some, the only change was a thickening of the endothelial layer, which became more granular. In others, the lumen of the vessel was filled with a rich, nuclear protoplasm. Dr. Grauer's opinion was that these nuclei were the nuclei of proliferated endothelial cells, rather than the nuclei of white blood-corpuscles, as held by some authorities. They were, he claimed, smaller and darker than the latter; and he had also seen an endothelial cell swollen and projecting into the lumen of the capillary, and completely obliterating its calibre.

With reference to the glomerulo-epithelium, he had noticed swelling and proliferation. It was still considered by some that it was the proliferation of the glomerulo-epithelium that produced a compression of the capillaries, and thereby obstructed the circulation; but in all the specimens examined by Dr. Grauer, although proliferation was present, the loops, as a rule, were larger than normal, showing that the pressure was from within, and not from without. Proliferation of the capsular epithelium was not observed in eighty-two sections

that he examined, although he had noticed it in other forms of scarlatinal nephritis.

Hypertrophy of the left ventricle of the heart was always present in cases of glomerulo-nephritis, and it was due to the heart's being compelled to do more work, on account of the obstruction in the Malpighian tufts. In conclusion, he expressed the opinion that the term glomerulo-nephritis ought to be limited to those affections in which there is an obliteration of the loops of the capillaries, and not applied to those in which there is only a proliferation and desquamation of the glomerulo- and capsular epithelium, as this change has been noticed in all forms of chronic nephritis.—*Boston Med. and Surg. Jour.*, Jan. 13, 1887.

DISEASES OF WOMEN.

Wark (D.) on the Treatment of Intra-Uterine Inflammation and Passive Hemorrhages with Extract of Hemlock.—The *extract of hemlock*, when placed in the interior of a diseased uterus, saturates the inflamed membrane by filling every follicle, and thus exerts its healing influence on every part. It is not only an astringent of an unusual power, but in addition it seems to possess a peculiar tonic influence on the tissue whose treatment we are discussing. For this reason we believe it to be specially adapted to the successful treatment of chronic endometritis, in which caustic applications have so frequently proved destructive.

We strongly recommend it to the confidence of gynecologists whose experience corroborates these views. Its application is nearly or quite painless, an advantage always highly appreciated by the patient. The extract may be applied in full strength to the uterine cavity by means of a probe, the end of which has been wound with absorbent cotton, or a few drops may be safely deposited there with a Molesworth intra-uterine syringe, or it may be dried until it attains the consistence of a soft pill mass; this done, a bit of the remedy the size of a pea may be passed within the os internum on the end of a uterine probe. Once in the cavity of the womb it soon dissolves and exerts its curative influence on every part of the diseased membrane. Convincing proof of the efficacy of the treatment here advocated is afforded both

to the physician and his patient by the improvement promptly experienced by the latter. The best results are secured by keeping the uterine mucous membrane under the influence of the remedy almost continually during a large part of the intermenstrual period. The applications should be repeated every second or third day. In cases of inflammatory disease of the mucous membrane lining the cervix, and in granular degeneration of the vaginal portion of the cervix itself, the use of the extract of hemlock, with such other local and general measures as will readily suggest themselves to every practical gynecologist, yields much better results than can be obtained by any other remedy with which we are acquainted. The following cases will indicate the effects that may be confidently expected from the use of this valuable preparation of hemlock in passive uterine hemorrhages:—

Case 1. A vigorous woman, forty-five years of age, who frequently boasted that she had never required the services of a physician except at the birth of her children, began to suffer from menorrhagia as the menopause approached. We saw her on one of these occasions after the flow had continued copiously for about a week; at this time it had lost the appearance of menstrual fluid and assumed that of thin, red blood. As the patient began to be anæmic, we applied the tampon daily during the next three days. The hemorrhage was controlled as long as it was in position, but as soon as it was removed, the blood reappeared and did not cease until the inside of the uterus was swabbed out with the extract in full strength.

Case 2. A lady aged thirty-five years, the mother of two children, began to suffer from profuse menstruation, which gradually increased month after month until it became a menorrhagia so copious that her life was saved on several occasions only by the diligent use of the tampon. This resource practically failed, as the hemorrhage returned shortly after the tampon was removed. The bleeding was, however, controlled by the use of the extract applied in full strength freely to the bleeding surface. At the next menstrual period the normal discharge was again followed by copious hemorrhage. We then examined the inside of the uterus, and discovered a small polypus, which we removed, with the result of obtaining a complete and lasting

cure. This case forcibly illustrates the power of this *extract of hemlock* over passive uterine hemorrhages.

Case 3. A married lady, twenty-six years of age, called me to attend her during a threatened abortion at the third month of pregnancy. She stated that this condition was brought about by herself, she having voluntarily taken some drug for that purpose. We found the loss of the ovum to be inevitable, and delivered her safely. The hemorrhage was not severe, and ceased without the use of local measures, and she made a good recovery. Menstruation began in about forty days, but instead of ceasing at the usual time, it became a copious hemorrhage. We did not lose time by resorting to the tampon, but immediately applied this valuable astringent freely to the inside of the uterus, when the blood ceased to flow forthwith.

In many cases of uterine hemorrhage the advantages obtained by the use of this preparation over other remedies—the tampon included—are obvious. After the application of the latter the hemorrhage always continues from the bleeding surfaces until the uterus is filled with blood, which, when it has coagulated, opposes further hemorrhage, if the blood does not unfortunately pass along the Fallopian tubes to the peritoneum. But when the loss of the vital fluid is checked by the use of the preparation here recommended, the blood ceases to flow immediately. The danger of producing a pelvic hematocoele, and the annoyance to the patient of a tampon in the vagina, are both avoided, in addition to the lasting tonic influence of the treatment on the spongy mucous membrane.—*Provinc. Med. Jour.*, Jan. 1, 1887.

Wigmore (W.) on Extraordinary Thickening and Induration of the Os Uteri.—At 3 A.M. on Dec. 8th, I was called to Mrs. H—, aged thirty-nine, in labor with her third child, the last being two years old; pains had been going on since the afternoon of the day before. On examination, I found the os dilated to about the size of a five-shilling piece, head presenting; anteriorly, the os was thickened and swollen into a mass under the pubes, the rest being quite an inch thick and tough. The liquor amnii had escaped a short time before. I tried for some time to dilate, but finding I could make no impression, and the pains getting stronger and almost incessant, I applied the long

forceps, hoping that with the aid of them and the fingers I might be able to dilate; but directly I used any traction, the os came quite outside the vulva, and I found it useless to attempt it. If I had used more force I should have pulled child and uterus away together. The pains were still incessant, the patient calling out for something to be done. I saw there was nothing left but to divide the os. But before doing so I wished for another opinion, and sent to Dr. Griffith, of Harrow Road. He asked me to remove the forceps and let him try to dilate; but, like myself, he found it perfectly useless, and agreed with me that nothing but division would give her a chance of being delivered. I accordingly re-applied the forceps, and, pulling the os outside the vulva, proceeded to divide it posteriorly. The procedure was like cutting cartilage or tendon, and there was no bleeding; directly it was divided the uterus split right up over the head of the child, which was immediately expelled. The child was dead. I was now fearful of the consequences, daily expecting to find symptoms of metritis, cellulitis, or peritonitis; but, on the contrary, the temperature never rose above 101°. She never had any abdominal tenderness, nor even a fetid discharge, and is now quite convalescent.

Remarks.—After the birth of her first child the patient suffered from a fall of the womb, and after that of the second it became worse, and eventually quite prolapsed. She never sought any advice for it. During the whole of her present pregnancy she was sitting on it, which gave her much pain, and her favorite seat was a chair with a hole in it. I suppose by the continual exposure and friction its character was quite altered. Having had a very large midwifery experience, and never meeting with a similar case, I am anxious to know what else I could have done. Craniotomy would have been of no avail, and I do not think that dismemberment would have been successful. I should also like to know now the peritoneum escaped—whether the recto-vaginal and vesico-vaginal folds were stretched by the gradual rise of the fundus and being held down below. I may here mention that after the birth of the child the uterus contracted well, the placenta came away without difficulty or hemorrhage, and the os was drawn well into the vagina.—*Lancet*, Jan. 8, 1887.

Young (J.) on a Peculiar Teratological Condition.—Mary M., æt. twenty-one, consulted him on the 3rd December, 1886. She complained of great weakness of the left side—so much so, that she could not maintain the erect posture. On examination of the thoracic walls he discovered the complete absence of the ninth rib on the left side, with slight lateral curvature of the dorsal vertebræ. On coughing there could be observed a large hernial protrusion between the eighth and tenth ribs, especially posteriorly. It was ascertained that the patient had *never* menstruated. A digital examination revealed the existence of a dense *imperforated* hymen. This, taken in connection with her age, as well as the existence of well-developed mammæ, with large nipples, led us to make still further exploration. Professor Simpson saw the patient with me, and the result of our examination proved the entire absence of all the uterine organs and vagina. The bladder and rectum were normal, while the external appearance of the genitals presented every indication of womanhood.—*Edinburg Med. Jour.*, Feb., 1887.

Currier (A. F.) on the Palliative Treatment of Cancer of the Uterus in its Later Stages.—He first referred to the origin of the term cancer, and then to the pathology of the disease. He then made some remarks on the question of local and constitutional origin, and also on the question of radical removal. The weight of opinion tends toward the view that it is of local origin, but that it reappears, and that radical cure after its first stages have been passed is impossible. The disease does not seem to be likely to be put on the list of affections due to a bacillus, and there are still too few data to enable one to speak with positiveness concerning the possibility of its originating by inoculation.

As to classification, he follows Waldeyer, and calls all the forms epitheliomata. By later stages he meant the period when constitutional infection has almost certainly occurred, the uterus is fixed, and ulceration exists to a greater or less degree.

If the patient can bear the operation, he advocated the removal of all the tissue which can be so removed with the scissors, then with the curette, and then, after the surface is thoroughly dried, apply the Paquelin cautery at red heat over the

entire field of operation. After removal of the slough, the surgical treatment will consist of vaginal irrigations of hot water, and suitable topical applications. Medicinal curative treatment plays an unimportant part. The hygienic and dietetic treatment are very serviceable.—*N. Y. Med. Record*, Feb. 5, 1887.

Is the Danger of Post-Partum Hemorrhage Increased by the Use of Anæsthetics during Parturition?

—Dr. Fordyce Barker says that his experience with anæsthetics in labor had been limited, since 1850, almost exclusively to chloroform, which he regards as preferable to ether—because the odor is less disagreeable; because it is less irritating to the respiratory tract; because it is more quickly effective, and in less quantity. It should be used intermittently, only at the time indicated. Dr. Barker employs chloroform to relieve pain in most cases of normal labor, and says that heart disease is not a contra-indication to its use when any anæsthetic is called for. He believes that with proper care no woman should die of post-partum hemorrhage due solely to uterine inertia. Chloroform hastens much oftener than it retards labor. It could not be shown to exert any injurious influence on mother or child. The only case on record of death after chloroform in labor, in care of a competent practitioner, was one in which the anæsthetic had been preceded by convulsions, and it was not proven that chloroform was the cause of death. Dr. Barker says he has never had post-partum hemorrhage occur in any of his cases except one, and in that chloroform had not been used.—*Bost. Med. and Surg. Jour.*, Feb. 10, 1887.

Abbott (G. E.) on a Combined Curette and Double Catheter.—The contrivance consists of a double catheter with a short curette screwed on the tip. Irrigation is kept up by means of an irrigating tube or a Davidson syringe.

The advantages gained are :

1. In making the parts thoroughly aseptic; the antiseptic fluid being allowed to run before entering the cervical canal, and during the time of operating.
2. The denuded surfaces are immediately covered by the antiseptic fluid before infection can possibly take place.
3. The detritus is immediately and fully removed.
4. The surgeon can see by the returns

in his white receiving-bowl what he is doing—fungosities, membrane, pure blood, or clear antiseptic fluid.

5. No bacteria are introduced, as in the use of the ordinary curette.

6. No fungosities or detritus remain to decompose.—*N. Y. Med. Record*, Feb. 5, 1887.

DISEASES OF THE SKIN.

Is Alopecia Prematura Contagious?—Dr. R. W. Bishop thinks this disease due to micro-organisms upon the shafts of the hair, and that it is contagious. He has made a series of experiments, assisted by Dr. Oscar Lassar. A typical case was that of a perfectly healthy young man whose head was nearly bald on top. The hair from the diseased surface was brittle and came out easily when pulled. Microscopic examination revealed a large number of fungi on the scalp and the shafts of the hair, the root being free from the parasite. The diseased hairs were cut and mixed with vaseline, which was rubbed on the skin of healthy rabbits, and in two weeks the hair entirely disappeared from the parts which had been rubbed. Experiments were continued, and it was found that the hairs from the inoculated animals possessed increased virulence.

The patient was treated as follows: The head was thoroughly washed for fifteen minutes with tar soap, which was removed with warm water. The head was then exposed to a warm-water douche, which was gradually cooled until the water was quite cold; it was then rubbed with a rough towel until dry, and afterwards washed with a solution of corrosive sublimate 1 to 500. This was removed and a $\frac{1}{4}$ per centum of lithol applied, and, after this, 1 $\frac{1}{2}$ per centum of carbolic oil was applied very slowly. The treatment was continued daily for eight weeks, and the result was a fine growth of new hair with beginning pigmentation at the end of three months.—*Chic. Med. Jour. and Ex.*, Nov., 1886.

Taylor (R. W.) on Iodoform Eruptions.—The conclusions drawn were: First, that iodoform quite frequently produced in those who used it freely—assistants at hospitals and dispensaries—a mild erythema, particularly of the fingers and about cuts, which caused little or no uneasiness, and ceased when the use of the

drug was discontinued; secondly, in certain cases of open granulating wounds, a longer or shorter time after beginning the use of the agent, two forms of erythema might be observed, the one simple, superficial, and more or less extreme, the other well-marked, attended with much œdema; both of these varieties might be complicated with papulation, vesiculation, pustulation, and in very bad cases with phlegmonous inflammation; thirdly, an eruption occurred from applying the agent to the throat or by smelling it, in which absorption of the drug occurred, and very soon severe dermal lesions of the face, head, hands, feet, etc., were seen; fourth, that in these cases there seemed to be a distinct iodoform idiosyncrasy, such as we see in some cases of quinine, iodide of potassium, and ipecac.—*N. Y. Med. Record*, Feb. 5, 1887.

Neely (E. A.) on a Case of Acute Acne.—Miss S., age nineteen; occupation dressmaker; menses appeared about thirteen; have always been and are now regular; were flowing when eruption made its appearance; two months ago had two chills; general health now excellent and appetite good; never suffered in any way with indigestion; no constipation; face has always been perfectly smooth, with the exception of chicken pox when she was small, and some years since a carbuncle on left cheek; no comedones present, and she tells me she never had them. Tuesday, August 23d, a small papular eruption appeared, disseminated over left side of face. On the following day, when I first saw her, the eruption covered entire face, consisting of pin-head and pea-sized papules and papulo-pustules surrounded by a broad zone of peripheral inflammation and a deep-seated inflammatory product. Lesions variously rounded and acuminated. I ordered the following: $\mathcal{R}$ Calomel, 2 grs.; mass. hydrarg., 2 grs.; aloin, $\frac{1}{4}$ gr., in two pills, to be taken at once, and $\mathcal{R}$ Calcii sulphide, grs. 4; syr. simplex, $\mathcal{Z}$ ii. M. Sig.—A teaspoonful three times a day, and put her on a diet of bread and milk.

August 28th. Condition very much worse. Nearly all papules which were developed when last seen had formed pustules and a new crop of papules had appeared. When the disease first made its appearance it was accompanied by slight itching and burning. None, however, exists now. The lesions were situated around the openings

of the hair follicles and sebaceous glands, and upon an extensive and indurated inflammatory formation. The pustules were acuminate in form, presenting a central suppurating point, and when lanced, discharged an astonishingly large quantity of pus, showing that the inflammatory process was deep down in the corium. They showed no disposition to rupture spontaneously, and each one was lanced and its contents squeezed out. Ordered hot water to be applied to face fifteen to twenty minutes at a time three times a day, and the sulphide of calcium continued.

August 29th. Pustules lanced yesterday look better. New ones had formed, and a fresh crop of papules had appeared, pin-head in size.

August 30th. Face improved; no new papules; accumulation of pus in some of the old pustules; these, with a few new ones, were lanced; treatment continued.

August 31st. Condition still improving; treatment continued.

From this time until September 4th she continued to improve, upon which date she was discharged cured, and given the following: $\mathcal{R}$ Zinci. ox., 3i; starch, 3i; hydrarg. ammonium, grs. x; vaseline, q.s. ad. $\mathfrak{z}$ i, to be applied to face under a mask at night.—*Miss. Val. Med. Mo.*, Oct. 10, 1886.

Cripps (H.) on a Case of Pemphigus Cured by the Application of the Oleate of Mercury.—The patient, a man aged fifty-seven, applied to the skin department, and was admitted into the hospital on May 14th. He had not been feeling well for some time, and during the last few months had been losing flesh, and feeling weak and depressed. He had never had syphilis or any other illness, except rheumatic fever when fourteen years of age. Until three months ago his skin was natural; at that time he noticed a few spots about the body; four weeks later blebs began to appear. These came out in crops, a great many appearing sometimes in one night.

On admission the patient was sallow and cachectic, looking older than his years. He complained of feeling weak and ill, and that the eruption caused considerable irritation. The whole of the body, except the face, was covered with a skin eruption. Very little healthy skin was to be seen. The eruption presented varied characters: large pigmented patches of irregular shape, and running into one another, formed an almost

continuous surface. On the trunk and limbs situated on this surface, were raised spots, very variable in size, some covered with scales, some with scabs, whilst others had a raw bleeding surface. Here and there were bullæ varying in size from a threepenny piece to that of half-a-crown. The bullæ were most numerous on the arms, back, and thighs; the contents of the bullæ were, in some spots, serum; in others, sero-pus.

May 22d. Since the admission he had been taking four minims of liquor arsenicalis three times a day. The right arm had been treated with a five per cent ointment of the oleate of mercury. The arm thus treated was greatly improved, all bullæ having disappeared. The eruption on the rest of the body remained much the same as when admitted. The oleate was ordered to be applied to the left arm.

June 8th. Great improvement had taken place in the left arm; the ointment was ordered to be applied to the right leg. There were no symptoms of mercurialism.

June 21st. For the previous week he had been taking eight minims of liquor arsenicalis three times a day. The limbs to which the ointment had been applied were now free from eruption.

June 30th. The ointment was directed to be applied to the rest of the body.

July 8th. The eruption had entirely disappeared from the whole body, nothing being left but pigmented patches, and here and there a few raised hyperæmic spots.

On July 9th he was discharged well. Whilst in the hospital, his temperature varied from normal to 100.5° Fahr.

Remarks.—The disappearance of the eruption in this case was certainly due to the ointment of the oleate of mercury. It was applied by instalments to the whole of the diseased surface, and the disappearance of the skin eruption strictly followed the local use of the ointment. It seems doubtful whether the arsenic had anything to do with the cure, for during the treatment, owing to an attack of diarrhœa, the liquor arsenicalis was discontinued for a week, nevertheless the disappearance of the eruption continued uninterruptedly during that time on the parts which had been treated by the mercurial ointment.—*Br. Med. Jour.*, Jan. 29, 1887.

Moore (W. O.) on Herpes Zoster.—The treatment consists in local and internal medication, and is mostly of the expectant character. Local treatment is di-

rected especially to the protection of the vesicles from irritation by the clothing; this is best done by anointing the parts with carbolic ointment or vaseline. Painting the parts with collodion makes a very good protective agent for the vesicles; in some cases, however, it temporarily increases the pain by contracting the skin in the vicinity. Hypodermatic injections of cocaine hydrochlorate over the nerve supplying the painful area will be of immense service. Ointments containing cocaine and morphine may also be applied to the vesicular patches.

For the painful neuralgias occurring after the healing of the vesicles, oleic acid containing some drug, such as morphine, cocaine, atropine, or daturine, may be used as an inunction. Static electricity has also been found extremely useful in allaying the severe pain, applied both over the course of the nerve and at its origin.

In ophthalmic shingles the eye-symptoms are treated in the usual way. Internally, quinine and iron are the principal remedies used.—*Quarterly Bulletin*, Jan., 1887.

MISCELLANEOUS.

Schede on the Healing of Wounds under a Moist Blood-Clot.—Dr. Schede states that it was after only a short experience with antiseptic surgery that he learned with the greatest astonishment that even large blood-clots in open wounds did not necessarily undergo decomposition, and produce inflammation and accidental diseases, but that the changes could occur in it, which are designated as "organization of the blood-clot," and which are similar to the changes taking place in a thrombus in a ligated blood-vessel.

Led to observations by such results, he soon arrived at the conclusion that, although the same results were obtained in various other ways, in none were they so quickly and certainly attained as by the method which he treats of in his monograph, viz., by the healing of the wound under a moist blood-clot.

He recapitulates the conditions necessary for healing under the blood-clot as follows:

1. The complete asepsis of the wound.
2. Precaution for the discharge of superfluous blood through suitable openings.
3. Care for the sufficient filling of the wound with blood.

4. Prevention of the evaporation of the blood in the wound, and

5. To favor as much as possible the evaporation and drying of the blood which overflows into the dressings.

The author concludes as follows: "Formerly, when blood left in the wound was looked upon as dangerous, the greatest care was taken to keep it clean, but to-day, when we recognize in the blood a most excellent plastic material, given us by nature herself, which fills cavities, and supplies loss of substance, which is more suitable than any other for supplying the loss of the protecting skin, which protects uncovered bone from necrosis, and unprotected tendons from death—to-day we are allowed in a large number of cases to intentionally fill the wound with blood, and we look upon it as one of the most beautiful consequences of antiseptics, that we have learned not only to render the blood in the wound not dangerous, but to compel it to serve a purpose in the healing process."—*Weekly Med. Review*, Jan. 1, 1887.

Ringer (S.) on the Influence of Small Quantities of Sodium, Calcium, and Potassium Salts upon the Cardiac and Skeletal Muscles of the Tortoise.—The conclusions from the experiments were, that saline solutions, when circulating through the system in such a way as to come in contact rapidly with muscular protoplasm, induce lessening or loss of contractility, and do so with great rapidity. Their action is exerted alike on cardiac and skeletal muscles. Lime and potassium salts brought into like intimate relation to muscle-protoplasm possess the power of exciting muscular contractility. Lime salt speedily restored contraction when stopped by saline solutions. These facts hold good for the heart muscles of the eel, the frog, and tortoise, and skeletal muscles of tortoise as well.—*Bost. Med. and Surg. Jour.*, Feb. 10, 1887.

Pomeroy (O. D.) on Multiple Paracentesis of Drum Membrane on the Hearing in Chronic Aural Catarrh.—The author, in performing this operation, guarded against undue injury of the membrane. The operation was usually attended with little pain. Cocaine might be employed. In not a single instance had a considerable amount of inflammation of the membrane resulted, and the hearing in none had been lowered. On careful examination he was compelled to admit that

the patient's statement was true regarding much improvement in hearing. Some of the cases had been under observation two years, and no tendency to relapse had been noticed. Twenty-four cases were reported.—*Bost. Med. and Surg. Jour.*, Feb. 10, 1887.

Daish (W. C.) on a Case of Acute Alcoholic Poisoning.—J. A., a strong young man, of about 25, was admitted on the 4th of November, 1886, having drunk a bottle of brandy, and also a bottle of castor-oil and soda-water.

On admission he was unconscious, cyanotic, with stertorous breathing, and pupils about equal, acting sluggishly to light, and a strong pulse; the limbs were lax and insensitive. The stomach-pump was used, and the stomach partly washed out, when passive vomiting came on, and the body and pelvis being raised much fluid drained from the mouth. This fluid smelt strongly of brandy. Ammonia was injected into the veins at the bend of the elbows, and he was bled to about $\frac{3}{4}$ xv.; this greatly eased the breathing and softened the pulse. Then hypodermics of ether were used half-hourly, and enemas of Warburg's tincture and milk every two hours were given, but the patient sank and died about ten hours after taking the liquids.

At the post-mortem examination the lungs were found gorged with bloody frothy fluid, with patches of extravasation throughout. The other organs and the mucous membranes were congested, and there was congestion and increase of fluid within the skull. The stomach showed patches of extravasation in parts.—*Australian Med. Jour.*, Dec. 15, 1886.

Ligatures.—Dr. Morton says that in the Pennsylvania Hospital ligatures are never applied except in the largest operative and accidental wounds. Sutures, run under or through the bleeding points, effectually control them. No trouble is experienced in tying catgut sutures or ligatures, when the first tie of the knot is made as for a surgeon's knot. Catgut is invariably used for these purposes. In treating some hundreds of scalp wounds, no matter how extensive, he has never applied a ligature, always finding that carefully placed sutures will stop all hemorrhage.—*N. West. Lancet*, Jan. 15, 1887.

Oliver (J.) on Menorrhagia as a Frequent Symptom of Pyonephrosis.—Menorrhagia is a symptom frequently

associated with pyonephrosis in the early days, and more especially when this disease appears on the left side of the body. It is the manifestation of a mere augmented and prolonged functional activity of the uterus and Fallopian tube, determined in some occult manner by the condition of the renal organ, whilst the periodicity of the flow itself is undisturbed. In such cases I have failed during life to detect any evidence of disease in the generative tract, and have twice verified this fact by a careful examination of the body after death, the uterus, Fallopian tubes, and ovaries being perfectly healthy.—*Lancet*, Jan. 15, 1887.

A Judicious Blend.—A would-be suicide was charged at the City of London Police Court last week with having taken poison. The particular agents employed appear to have been a curious mixture of sugar of lead and sulphate of zinc. If the conjunction were due to purely fortuitous circumstances the accused is to be congratulated on the fact that there is a providence which shapes our ends. An accomplished chemist could scarcely have devised a better formula for the use of desponding persons who do not altogether care to shuffle off the coil. The woman—for the culprit was a female—was stated to have been insensible when discovered, but doubtless this partook of the nature of the sudden paralysis which has been known to affect duellists immediately on the discharge of the pistols even when, thanks to the prudence of the seconds, nothing worse than wadding was to be feared. Although no very dreadful results were to be apprehended from the ingurgitation of the mixture, its effects on the stomach may very possibly have been such as to render the genuineness of the regrets which she expressed very probable. We venture to hope that these unpleasant reminiscences will suffice to deter this unfortunate person from any further attempts on her life, wretched though it be.—*Med. Press*, Jan. 12, 1887.

Serebrennikova (E.) on Stretching the Optic Nerve.—The left eye was totally blind for two years and presented an atrophic excavation; its pupil was dilated and immobile. With his right eye the man could rightly fix the light of a window or candle, and see a passing man or moving hand as "something black"; the right pupil was normal. She performed stretch-

ing of the left nerve after De Wecker's method. On the next day after the operation, the left pupil contracted to the normal size; on the fifth, the left eye could rightly fix candle-light. On the seventh, could distinguish movements of an arm or glistening objects (such as silver spoons). At the same time sight of the right eye improved to such an extent as to allow the patient to count fingers at the distance of a foot. No further improvement was observed during the next week (up to the date of the article.—*London Med. Record*, Jan. 15, 1887. A. T. M.

ERRATUM.

Owing to editorial oversight, Dr. Buck's article, pp. 127-128, was not duly credited to *N. Y. Med. Record*, Jan. 1, 1887.—ED.

BOOK NOTICES.

Wear and Tear; or, Hints for the Overworked.—By S. Weir Mitchell, M.D. 5th edition, 76 pp., price one dollar. J. B. Lippincott Co., Philadelphia, Penn., 1887.

In the preface the author says, although "vast changes for the better have come about in many of our ways of living, there is still need to repeat and reinforce my former remonstrance as to ways of living, dress, diet, and education." To this view there will probably be not one dissenting voice. How much better would it be if all did not only not dissent from but practised the doctrines advocated in this little book.

By far the most important teachings of the book seem to be a protest against overwork, and overwork in schools particularly as affecting the health of girls and their becoming healthy mothers or mothers at all. This is by no means alone the fault of the teacher or the system of education, but can often be laid at the door of parents or irregular living at home or at school. As to co-education the author says: "Surely no system can be worse than that which complicates a difficult problem by taking two sets of beings of different gifts, and of unlike physiological needs and construction, and forcing them into the same educational mould."

The title of the book is so familiar and its contents so sensible that it needs no word of commendation on the part of a reviewer while its unpretentiousness disarms criticism.

Transactions of the Association of American Physicians. First Session, Washington, D. C., June 17 and 18, 1886. Wm. J. Dornan, Printer, Phila.

This is a well-indexed volume of 261 pages, containing, as its name implies, the proceedings, etc., of the first meeting of a new national medical association. Most if not all the papers contained in the book have appeared already in medical periodicals, and not a few have been noticed in *THE MEDICAL ANALECTIC*. The names of the contributors are a sufficient guaranty of the excellence of the papers, and promise a continued existence and usefulness of the association.

PUBLISHERS' NOTES.

Horsford's Acid Phosphate.—Cases of Skin Eruptions and Syphilis Treated with Horsford's Acid Phosphate. By Dr. JAMES STARTIN,

Late Honorary Surgeon and Lecturer, St. John's Hospital for Skin Diseases, London: Honorary Consulting Surgeon to the Sheffield Public Hospital for Skin Diseases.

It appears to me that the "Acid Phosphate" originally prescribed by Prof. Horsford, of Cambridge, U. S. A., is not so well known in this country as its merits deserve. A glance at the formula will, however, readily convince one of its value in suitable cases. Each fluid drachm gives, on analysis, 5½ grains of free phosphoric acid, and nearly four grains of phosphate of lime, magnesia, iron, and potash. The following are a few brief notes of some of the cases in which I have prescribed it with complete success.

Mr. G., æt. sixty-nine, consulted me November, 1885, for eczema on the arms, legs, palms of the hands, and trunk. The patient complained of much debility and nervous exhaustion, and he was a man who had led a very busy business life, with much worry. In December, 1885, I prescribed Horsford's acid tonic with much good effect, as in February, 1886, I heard that he was quite well.

Mrs. S., æt. forty-six, consulted me in December, 1885, for psoriasis, all over the body, more or less, especially on the legs and arms. In January, 1886, I prescribed a teaspoonful of the acid tonic three times a day with marked good effect. Patient had been much exhausted by continuous nursing on an invalid mother.

Mr. C., æt. sixty-four, consulted me in September, 1885, with one of the worst attacks of late syphilis I ever saw. After he had been relieved from the distressing symptoms, and ulcerations, I prescribed the acid tonic for epileptiform fits from which he suffered, with excellent results.

Mr. McJ., æt. sixty-three, consulted me in November, 1885, for lichen ruber, which was accompanied with intolerable itching. He was a nervous, irritable man. I prescribed the acid tonic with the effect that in December he presented himself quite convalescent. — *Medical Press*, London, Eng.

Peacock's Bromides.—I have used Peacock's Bromides in a number of cases.

with the best results, especially in epilepsy ; one case in particular, C. S., a railroad man, having been compelled to quit work on account of the paroxysms coming on every day. After one week's treatment with Peacock's Bromides, the attacks were considerably lessened ; now, after two months' treatment, he seems entirely cured and has resumed work. Any case where there is a nerve sedative indicated I can cheerfully recommend Peacock's Bromides. W. H. WOLFORD, M.D.

2634 State St., Chicago, Ill.

Colden's Liquid Beef Tonic.—* * * "Colden's Liquid Beef Tonic" is an excellent preparation, whose composition is known, and one that physicians can intelligently prescribe. I have found it of great service in my practice.

DR. BENJ. H. BRIGGS.

Selma, Ala.

Murdock's Liquid Food.—Woman's Christian Temperance Home, 440 East 57th St., New York, June 23, 1883.

DEAR SIR: We find your Liquid Food very useful. Respectfully yours,

A. P. MEYLERT, M.D.

Adjustable Operating Chair.—Write to M. Klein, Chicago, Ill., for catalogue of his operating chairs and invalids' wheel chairs.

Lactopeptine.—I have used *Lactopeptine* in seven cases of obstinate *Vomiting in Pregnancy*, with perfect success in each case. V. H. MOORE, M.D., M.C.P.S., Ont.

Brockville, Ont., Canada.

Lactated Food.—New York Hospital, West 15th Street, N. Y., January 2, 1885. Wells & Richardson Co.—GENTLEMEN: We received recently a sample lot of your Lactated Food and gave it a trial. We think well of it. Enclosed please find order for quantity for further trial.

Yours truly,

GEO. P. LUDLAM, Superintendent.

Aletris Cordial.—I have used Aletris Cordial (Rio) with the happiest results, in an aggravated case of Prolapsus Uteri and Leucorrhea of three and a half years' standing. The patient is now using the second bottle, and it has given her more relief than any other medicine before prescribed. I am so favorably impressed with it that I shall prescribe it in all cases to which it is adapted in the future. S. MONG, M.D.

Cincinnati, O.

Pinus Canadensis.—A thorough trial of Kennedy's *Pinus Canadensis* proves it to be all that is claimed for it as a mucous astringent.

W. T. COGGINS, M.D.
Covington, Ga.

Crystalline Phosphate.—GENTLEMEN: I received the sample of "Crystalline Phosphate" a few weeks since, and was well pleased with the results obtained from it, and would not hesitate to recommend it in preference to any preparation of the kind, which I have seen or used.

Very truly yours,

ALVIN S. BUTLER, M.D.
4306 Maplewood Ave., Chicago, Ill.

Abdominal and Uterine Supporter.—Send to G. W. Flavell & Bro., Philadelphia, Pa., for catalogue of their supporters, which are widely recommended.

The Improved American Pocket Battery.—The Pocket Battery, manufactured by the Electro-Medical Battery Co., Kalamazoo, Mich., is used extensively throughout the United States and Canada. Send for circular.

Iron-Alum Mass.—I have had great success with "Seven Springs Iron-Alum Mass" in treating Female Diseases ; it is a desirable medicine, and should be used more extensively by the profession.

E. T. BAINBRIDGE, M.D.
Baker's Station, Tenn.

Cod-Liver Oil Tonic.—In prescribing cod-liver oil, if you order Scott's Emulsion you will give your patient not only a pure oil but a combination holding the hypophosphites of lime and soda in intimate mixture.

Phillips' Palatable Cod-Liver Oil (Emulsion). The Chas H. Phillips Chem. Co., 30 Platt St., New York, will send an illustrated circular in regard to their Palatable Cod-Liver (Emulsion), if ANALECTIC is mentioned. See advertisement.

Physicians' Medical Exchange.—The attention of our readers is called to this advertisement on another page ; if you wish to dispose of your practice or to purchase another, write for information to J. S. Fitzgerald, 285 Broadway, New York.

Massachusetts Water.—Recommended by the profession for Malarial Troubles and as a Nerve Tonic for Females. Write for circular containing testimonials and other valuable information ; see advertisement.

THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

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WHOLE No. 40.

LEADING ARTICLES.

Bowditch (V. Y.) on the Use of *Strophanthus Hispidus* in Heart Disease.—A little more than a year ago, Professor Fraser, of Edinburgh, published the results of fifteen years' experience with a drug, till then, all but unknown to the medical profession. The feeling of respect due to such an accurate observer and careful experimenter as Fraser; the experience of several of our New York associates, as well as the comparatively recent facts brought to my notice in our own community, are the reasons of my calling your attention, this evening, to the use of *strophanthus* in diseases of the heart.

In the *British Medical Journal* of November 14, 1885, one may find the full account of Fraser's experiments; and I will, therefore, only call your attention to a few of the most important characteristics of the drug, hoping thus to induce you to give it a careful trial in your own practice, if you have not already done so.

The plant is indigenous to Africa, and is used by the natives as a poison for arrow-heads. It is of the digitalis group, and has a distinct action upon striped muscular fibre, and also upon the heart; and, in poisonous doses, causes greatly increased and almost continuous cardiac systole, with consequent paralysis of the heart and early cadaveric rigidity.

By a series of experiments patiently carried out over a number of years, both clinically and in the laboratory, Fraser has arrived at the following conclusions:

First. That *strophanthus* has a distinct action, like digitalis, in increasing the force of systole, at the same time diminishing the rapidity of the heart's action; whether by stimulation of the organ, or direct action upon the heart muscle, he is not prepared to say.

Second. That it has little or no effect upon the blood-vessels; and, therefore, causes less blood-tension than digitalis, which, either by vaso-motor influence or direct action, or both, causes a contraction of the vessels, with a consequent rise of blood-tension.

Third. That it causes less gastro-intestinal disturbance than digitalis.

Fourth. That it possesses, like digitalis, both antipyretic and diuretic properties.

Fifth. That, unlike digitalis, it is not cumulative in its effects; and

Sixth. That it may be used in smaller doses than digitalis.

If Fraser's conclusions prove true in practice, we find a decided weight in the balance in favor of *strophanthus*; and, although experience teaches us to be cautious in accepting the much-vaunted virtues of any new remedy, yet the facts brought to our notice by one of such eminence should make us unhesitatingly experiment for ourselves.

Fraser has used *strophanthus* in the form of a tincture, in doses varying from *three* to *twenty minims*, twice or three times daily; but, in a recent article, he speaks of the dose as varying from five to ten minims. He has also experimented most successfully with the subcutaneous injection of the active principle, *strophanthin*, a glucoside, in doses of $\frac{1}{10}$ of a grain; and, by this means, has noticed much more lasting effects from one dose than with the tincture. In one case, with severe symptoms from mitral regurgitation, the marked beneficial effect upon the heart's action by a single subcutaneous injection of $\frac{1}{10}$ gr. of *strophanthin* was noticed for eight days.

In the *New York Medical Record* of December 18, 1886, among the "Transactions of the Practitioners' Society of New York," are reports of cases by Dr. C.

L. Dana, the only ones yet made public, so far as I know, in America.

Dr. Dana's results, in a comparatively small number of cases, are such as to make him believe that strophanthus, as now used here, is a valuable addition to our pharmacopœia, and can be often used in cases where digitalis is not so efficacious.

The testimony of other observers seems to point towards the favorable action of strophanthus, some believing that, eventually, it will supersede digitalis in the treatment of heart disease.

My attention was especially called to the drug by a well-known lady physician of this city, who is enthusiastic over its action in her own case, and has kindly allowed me to quote her experience with it.

During the previous year, this lady, a sufferer from a mitral lesion, was very ill, in the south of France, with pneumonia, during the progress of which the heart became very troublesome. At the suggestion of her physician, during her convalescence she began taking strophanthus; and, before twenty-four hours had passed, experienced the greatest relief from the breathlessness upon the least exertion, which had been one of her most distressing symptoms. The improvement continued steadily, until, by the advice of a physician in another part of France, she ceased to take strophanthus, when the former symptoms returned. Repeated experiments have shown her conclusively that the drug gives her great relief from dyspnœa, and its effects are always more pleasant than those of digitalis. In the use of the latter she had always experienced a depressing effect, coupled with gastric disturbance; with strophanthus, however, the effect is always rather exhilarating, and it has never caused the slightest trouble with the digestion. Its action is always markedly diuretic; and, although she has never taken it in doses sufficiently large to carry the pulse below the normal rate, it has always had a distinctly calming effect upon the heart. She continues to use the drug, omitting it at times for a few days, and always experiences the same sensations upon resuming it again. Her testimony, therefore is distinctly in favor of strophanthus as a substitute for digitalis.

Acting upon these suggestions, I was, fortunately, able to try the drug in a case

of severe heart disease, transferred to me by Dr. F. I. Knight, in which a slight mitral systolic murmur, great dilatation of the left ventricle, pulmonary œdema, a very rapid, irregular, intermittent pulse, and almost constant orthopnœa, were the chief symptoms. For several weeks, almost constant use of the tincture of digitalis, and trials of sparteine and caffeine, had failed to effect the action of the heart muscle, the pulse varying from 140 to 110 to the minute most of the time. Tincture of strophanthus, in doses of about three or four minims three or four times a day, was tried; but, owing to some rather obscure symptoms, which I then thought might arise from the drug, it was discontinued after the third or fourth day; and although the patient insisted that she liked the medicine, and that she breathed more freely, I noticed no special action upon the heart or pulse.

Soon after this, the patient developed signs of congestion in the lower part of the left lung, namely, dulness and slightly bronchial breathing; râles from rapidly increasing pulmonary œdema were heard on both sides; the legs, arms, and face were swollen, the dilatation of the heart increased, and relief from great dyspnœa was obtained only by subcutaneous injections of morphine.

The husband of the patient having heard that Dr. M. L. Chamberlain of this city had had experience with strophanthus, suggested a consultation to which I gladly assented, and at his advice the strophanthus was again tried and gradually pushed. It was given finally in doses from fifteen to twenty-three drops by the ordinary glass dropper (about equivalent to ten or twelve minims) three or four times in the twenty-four hours; digitalin, in doses varying from gr. $\frac{1}{16}$ to gr. $\frac{1}{8}$, being given between the doses of strophanthus when the patient was awake. It would be quite unfair to attribute all the gain which immediately followed to strophanthus, for although digitalis as used before in the tincture had not had the slightest apparent effect upon the pulse, yet the use of digitalin naturally makes it impossible to say which was the larger factor in the improved condition of the patient, but the following facts were noticed: rapid decrease of the dulness and bronchial breathing over the congested portion of the left lung, great diminution in the number of râles through-

out the chest; the swelling of the arms and legs diminished; the dyspnœa was less marked; the action of the heart became much less feeble, while the pulse slowly dropped from 120 to 88, became perfectly regular, and lost its intermittent character. This improvement continued for about a week, when a curious friction sound appeared near the angle of the left scapula, the exact nature of which it was impossible to determine, and that night the patient, while sitting up during a movement from the bowels, suddenly fell back and expired. No autopsy was allowed.

Synopsis of case.—Patient suffering intensely in the last stages of mitral disease, after receiving no apparent benefit from the tincture of digitalis, sparteine, or caffeine, obtains very great relief from somewhat large doses of tincture of strophanthus alternating with digitalin.

Another case in which I have noticed a markedly beneficial effect from strophanthus is a lady sixty-three years of age, for years a sufferer from valvular disease in which dyspnœa and great irregularity of the heart's action are the chief symptoms. During a severe illness last November, from which I never expected her to recover, all the most serious symptoms were greatly relieved by three or four minims of strophanthus given three times a day. General œdema of the legs disappeared; the action of the heart and pulse steadily improved, and the latter, which by the use of digitalis had fallen to about 45, rose again to about 60, and although occasionally intermittent was more regular than I had ever known it under the previous use of digitalis. The patient is now vastly improved in health, moves about the house, is able to go out to drive or walk, and still takes about three minims of the strophanthus three times a day, and although the pulse still intermits and is somewhat irregular, the action of the heart is much less tumultuous than before, and varies from 65 to 80 beats in the minute.

The last case in which I have used the drug is a man about fifty-eight years of age, who has had symptoms which point to fatty degeneration of the heart, namely, a weak, rather irregular and rapid pulse with occasional attacks of faintness. This patient seems not at all sensitive to the drug, and I have gradually increased the dose to fifteen minims four times in the twenty-four hours. Although the pulse has never

fallen below 86 and usually is about 94 or 96 to the minute, it is now of very good strength, and perfectly regular ever since he began to take the tincture about five or six weeks ago. Previously the pulse had often been above 100, and at times very weak. The general condition has slowly improved; there has been no recurrence of the attacks of faintness, and as the patient tells me he has always had a rapid pulse I have not attempted to reduce its action further, and am at present diminishing the dose again to see how far the drug has a controlling action upon his heart.

From such a meagre array of cases I should, of course, be unjustified in making any remarkable claims for the drug, but the experience of others, combined with the results of my own observation, makes me feel it should be brought before the profession and tested.

As to the preparations now in use in this country, I only know of the tincture and the soluble triturate tablets as prepared by Fraser & Co., of New York, in which one tablet represents one minim of the tincture.

I have reasons for believing that the tinctures which I have thus far tried, made by some of our best-known firms here, are not yet of as good a quality as those prepared by Prof. Fraser or by Messrs. Duncan and Flockhart, of Edinburgh.

Through the kindness of the lady-physician already referred to, I have seen the Edinburgh preparation, and instead of having a greenish hue, it is colorless, has a slight but distinct odor of sulphuric ether, leaves no precipitate when added to water, and has a less bitter taste than these tinctures which I have seen here.

I can but think, moreover, that our present preparations vary in their strength; a fact which makes thorough experimentation much more difficult, but by keeping in mind the same general principles which guide us in the use of digitalis, chiefly watching the character of the pulse, we shall be enabled to test the comparative value of strophanthus, with little danger of doing harm.

It is to be hoped that before long we can make experiments with the active principle strophanthin, which Fraser tells us is a much more efficacious method of administering the drug than any other.

Increased facilities for obtaining the plant from Africa will doubtless before

many months not only enable our druggists to give us this form of *strophanthus*, but at a greatly reduced price.—*Boston Med. and Surg. Jour.*, March 17, 1887.

SUPPLEMENTARY NOTE ON THE MODE OF PREPARING THE TINCTURE OF STROPHANTHUS.

[Fraser's method is as follows¹: *Strophanthus* seeds, deprived of their comose appendices, reduced to powder, and dried, 1 ounce or 1 part. Ether, freed from spirit and from water, 10 fluid ounces, or 10 fluid parts. Rectified spirit, a sufficiency to obtain 1 pint, or 20 fluid parts.

Remove entirely the stalks and comose appendices from the seeds, reduce the seeds to a moderately fine powder, dry the powder by exposing for twelve hours to a temperature of 100° or 120° Fahr., and weigh. Pack in a percolator (the percolator being furnished with air valves, or being otherwise so constructed that the percolation may be arrested when desired), add ether until the whole of the powder is saturated, and a small quantity of the ether has dropped into the percolator; arrest the percolation for twenty-four hours, and then continue percolating slowly until the whole of the ether has been used. If the last ether percolate should not be almost colorless, use more ether.

Remove the powder from the percolator; expose to the air, and break up any lumps after the ether has sufficiently evaporated; and continue the exposure, heating the powder, if necessary, to 100° or 120° Fahr., until all the ether has evaporated, when a uniform, nearly white, dry powder may easily be obtained.

Repack the powder in the percolator, add enough of rectified spirit to moisten it thoroughly; arrest the further flow of the spirit, and macerate for forty-eight hours; and pass rectified spirit slowly through until twenty fluid parts of tincture have been obtained.

In this process, the preliminary extraction with ether is for the purpose of removing the large quantity of inert oil contained in the seeds, which, if present in the tincture, would cause it to become opalescent on the addition of water.

The dose of this tincture is from five to ten minims. It may also be used in doses of half a minim to two minims, frequently

repeated. It is nearly colorless, having a very pale yellow tinge; neutral in reaction, and intensely and rather persistently bitter in taste. It mixes unchanged with water, is not precipitated by solution of tannin, but becomes markedly opalescent when ether is added to it. Solution of perchloride of iron intensifies its yellow color, and at the same time produces a slight haziness in the solution; and, after some hours, the slightly opalescent fluid acquires a greenish-yellow color.

The chemical and pharmacological experiments which I have made show that the seeds contain a much larger quantity of active principle than any other part of the plant. The pericarp of the follicles, and the comose appendices of the seeds, contain a relatively small quantity, and the quantity is not the same in each part of the pericarp. The seeds furnish the most convenient and trustworthy preparations for therapeutic administration, and they alone should be used for preparing the tincture.

Dr. Richard J. Purdon, Belfast, writes²: In the literature concerning *strophanthus hispidus*, I do not remember seeing any precautions recommended to be observed in making preparations of this drug; therefore, I think the following may be of interest to your readers, especially to those who are practical pharmacists: A short time since, I had occasion to order a small quantity of the tincture from one of our principal chemists, and was surprised to hear that the gentleman who was engaged in preparing it was suddenly affected with severe headache, about the junction of the skin and hairy scalp, which gradually spread to the temples; this was accompanied by double vision, succeeded by impaired sight of left eye, nausea, but no actual vomiting, coldness of extremities, and faintness. He was treated by diffusible stimulants, but it was several hours before the effects passed off. The manager of the compounding department was similarly affected, but in a less degree. Mr. Martindale, I am informed, states that irritation of the mucous membrane is caused by preparing this drug, possibly through inhaling some of the hairs as they are cut off; but, so far as I am aware, he does not mention any effects such as the foregoing.]

¹ *Brit. Med. Jour.*, Jan. 22, 1887.

² *Brit. Med. Jour.*, Jan. 29, 1887.

Renshaw (C. J.) on a Comparison of the Poisons of Diphtheria, Scarlet-Fever, and Membranous Croup, as Shown by Administration to Animals.—The diseases which are most similar to diphtheria are undoubtedly scarlet-fever and membranous croup, and not forgetting, as already mentioned, that it is sometimes complicated with one or other of these diseases, the chief distinctions between it and them are the following: In diphtheria the lymphatics at the angle of the jaw are enlarged, rarely so in scarlet-fever. The membrane in diphtheria is of a grayish-white or yellowish-white color, and is a distinct membrane characterized by the coagulation not merely of the lymph poured out with the epithelium, but also of that effused into the submucous connective tissue. In scarlet-fever, where ulceration exists, it is of a yellowish color, and there is no membrane which can be peeled off, as in diphtheria. In diphtheria the whole of the membrane can, as a rule be removed, leaving the raw surface below, which immediately exudes fresh membrane, thinner and thinner as the case is recovering.

In diphtheria, albuminuria frequently arises on the second day, without the patients having apparently taken cold; in scarlet-fever that takes place rarely till after the sixth day, and then seldom unless after cold and exposure. Then there is the rash, which exclusively pertains to scarlet-fever.

In diphtheria we frequently have paralysis, which never arises in scarlet-fever *per se*.

I have, as reported in the *Practitioner* of January, 1885, communicated diphtheria from man to the carnivorous animals. I have been able to cause a kind of fever in the graminivorous animals from scarlet-fever poison. Then, from a diphtheria patient I injected some liquor sanguinis, causing death in a rabbit in seventeen hours, from congestion of the lungs, and in a frog in twenty-four hours, whereas from similar treatment with liquor sanguinis taken from a scarlet-fever patient, the rabbit had only a slight illness resembling the usual symptoms of scarlet-fever, without the rash, and was quite well on the tenth day after the operation. The following experiments prove the communicability of diphtheria from man to animals.

June 6, 1874.—Having seen that the stomach and bowels of a cat were emptied,

I administered some diphtheritic membrane of a whitish-gray color taken from the throat of a living patient. Result: Death from diphtheria on the seventh day. On examination I found patches of diphtheritic membrane on the mouth, fauces, and lining of the bronchial tubes, also in parts of the bowels. The small amount of urine I was able to collect from the bladder was highly albuminous, the kidney was of a whitish color.

To a second cat also was given some similar membrane. It died from diphtheria on the thirteenth day, having begun to be ill on the fourth. It suffered from a severe attack of the disease. The post-mortem examination showed the diphtheria lining the whole mucous tract from the mouth to the lower part of the rectum. The urine was albuminous, the kidney similar to what one meets with after scarlatinal dropsy.

June 8th.—To a cat, death occurring on the ninth day from diphtheria.

June 9th.—To two mice, death occurring on tenth and thirteenth days from that disease.

June 10th, 11th 12th, 13th, 14th 15th.—I saturated some membrane taken from the same case with a solution of permanganate of potassium. This gave negative results, on administration to animals, in nine cases. I also got negative results from saturating the diphtheritic membrane with hypochlorous acid, and using it for a like purpose.

June 12th.—Placed a piece of membrane in the wound of a cat and got well-marked diphtheria in three days. The animal recovered.

June 16th.—Same experiment. Result: Diphtheria in five days. The animal had an attack of paralysis of left hind leg twenty-one days afterwards. It recovered in seventeen days. I made fourteen experiments on animals with the yellowish-white membrane. They were all failures.

The seven experiments on similar animals made with grayish membrane were all successful—that is, the diphtheria was conveyed to these animals. It would seem, therefore that the grayish-white membrane was the most virulent.

Buhl, Hüter, and Oertel discovered a micrococcus which they claim to be the *micrococcus diphthericus*.

But Wood and Formad of Philadelphia say that it is the same as the *micrococcus septicus*, thereby only showing that diphtheria is a septic disease.

The *micrococcus scarlatina* is said to be smaller in the proportion of 00.35 to 00.5. The inoculation of these scarlatina micrococci by Coze, Feltz, and Riers generated a fever-like disease in rabbits. Ransome, Braidwood, and Vacher found these micrococci in the breath of patients affected with measles. But taking Wood and Formad's experiments, they merely show that the microbe of diphtheria and of ordinary septic throat is one and the same. Whilst they clearly prove they can cause diphtheria by the injection of the microbe into animals, in no case has this injection caused scarlet-fever, showing very greatly the difference as to the microbe at least, and therefore, presumably, as to the disease.

Although it is apparent that Löffler made his experiments with the utmost skill and care, and though he produced a kind of membrane upon animals from the injection of the cultivated microbe of diphtheria, yet it is by no means certain that he produced true diphtheria, and certainly not scarlet-fever. It seems to me to be evident that there is a difference between the two diseases.

The following cases seem to show that the cause of diphtheria in all probability is neither from a ferment of decaying vegetation nor of animal decomposition alone, but to a combination of the dual poisons when mixed in a state of putrefaction.

Case 1.—A heap of vegetable matter, on October 1st, was mixed with a quantity of animal matter by two men. Both heaps were on the ground for some months. Neither of the men were taken ill. This mixed heap was distributed over a field on March 1st. One of the men who distributed it, and a boy who assisted him, were taken ill of diphtheria, one on March 3d, the other on the 7th.

Case 2.—A similar heap, similarly treated, was spread on a field adjoining a house in which there were children. The two men who carted the material on to the field, as also the five children, were all ill of the disease within fourteen days.

Case 3.—A heap of ordure, close to a house, having been there for a considerable time, was mixed with some vegetable debris. No one was ill then, but three months afterwards, it being opened and used for the garden, four children residing in the house were seized with diphtheria.

Case 4.—Two children were playing on a

heap of animal and vegetable manure, just opened. Four days afterwards the first child was taken with diphtheria, and two days later the second child fell ill with the same malady.

Case 5.—Some strong mixture of blood and vegetable matter was spread on a rose bed. A little child watched the process, was sick at night, and four days afterwards was suffering from diphtheria. There was no other case in the neighborhood, and the child had not been out of its own garden.

We do not seem to have much diphtheria in those immense slaughtering places in Europe, or South America, where, if anywhere, we might expect to have that disease if it arose simply from decaying animal matter; nor yet from the heaps of decaying vegetation left in the neighborhoods of our markets, such as Covent Garden, if vegetation in its resolution were the cause of the disease.

Now, is this only an accident? Are these various decompositions only waiting the favorable moment to become of themselves hot-beds for the propagation of diphtheria? or do not rather the cases I have quoted point at the probable necessity of the cause having to do with the duality of the poisons of animal and vegetable decomposition?

The evidence that diphtheria may arise from decaying vegetable matter is *nil*. With regard to animal decomposition of itself causing it, it is but fair to say Dr. Parsons thinks he has found it to arise in one case from the smell of a foul ulcer, and in another from the dissection of a putrid dog. With these exceptions, I find no evidence of merely animal decomposition being the cause of diphtheria.

It would appear from the experiments already mentioned that there are two forms of membranous exudation—the yellowish-white, from which no consequence was produced when the membrane was administered to animals, and the grayish-white membrane, which produced true diphtheria, it being exhibited in the same way to similar animals.

It also shows clearly the fact that the free application of permanganate of potassium and hypochlorous acid destroyed the septic influence of the *micrococcus diphthericus*, or the poison of the disease, whatever it is.

The question whether diphtheria and

membranous croup be one and the same, or whether they be two distinct diseases, is a matter of the utmost importance. The following experiments will perhaps do something towards elucidating that point:

On October 1st, a child, after playing some time in cold, rain, and wind, went home complaining it was cold. At three o'clock in the morning the child was very feverish, with a barking cough. Twenty-four hours later this developed into a severe attack of membranous croup. The following morning she vomited a considerable quantity of croupous membrane, exactly similar in appearance to the grayish-white diphtheritic membrane I had just been successfully experimenting with on animals, not even differing in appearance under the microscope. I divided this membrane into two pieces, giving one part to a healthy cat; the other part was given to a cat with a sore throat; but in neither case was there any disease produced.

In December a child was driven in an open wagon. It complained of being very cold. An east wind was blowing at the time. Twenty-four hours afterwards a severe attack of inflammatory or membranous croup supervened. Having obtained a cast of croupous membrane from the throat, I gave part of it to three cats, without any effect being produced upon them whatever.

February 22d. A child suffering from croup vomited a large quantity of membrane, similar in appearance to that already experimented with. Portions of this were placed in a wound of the axilla of a cat and of a rabbit, but had no effect, differing entirely from the similar experiments with the membrane of diphtheria. A portion was given to three mice, two hens, and a rabbit, without any effect.

March 12th similar experiments were made with a dog and a cat, by the administration of the membrane of membranous croup, but all alike failed. Five other experiments yielded negative results also. There was no similarity in the appearance of the membrane used to the yellowish-white membrane of diphtheria, which I had used unsuccessfully in endeavoring to inoculate that disease upon animals, but the membrane was to all appearance like that grayish-white membrane of diphtheria, with which I had infected several animals with diphtheria. It would seem to me that these experiments go very far towards showing

that there is a difference between membranous croup and diphtheria.

It is scarcely necessary to consider the various objective symptoms of inflammatory croup, these are so well known; but I would mention, in contrasting that disease with diphtheria, its extreme rarity as an epidemic, the absence of general paralysis after it, the absolute immunity from albuminuria, and the absence of contagiousness. — *The Practitioner*, Feb., 1887.

Phelps (G. B.) on Minor Surgery at the Chambers Street Branch of the New York Hospital. — The outpatient department of the Chambers Street Hospital is for the treatment of surgical cases only.

As a rule, the patients pay very little regard to cleanliness, and many are almost tramps. The dispensary assistants are, besides two of the house-staff, either third-year students or recent graduates. The work in the traumatic class is done almost wholly by gaslight. These conditions are mentioned to show under what circumstances the work is carried on.

Fresh cases have the surface about the wounded part washed with soap and water, and, if covered with oil, cleansed with ether. The wound is then thoroughly irrigated with a 1:1000 solution of bichloride of mercury. If there is hair about the part, this is removed with a clipping-machine or a razor.

Incised and lacerated wounds of the scalp, after checking the hemorrhage by clamping and tying any bleeding points, or by pressure, are sutured with catgut, without drainage, unless the wound is very extensive. Contused wounds are similarly treated, unless there is much contusion of the edges, when the wound is packed loosely with wet bichloride gauze. Over the wound a compress of plain absorbent gauze, freshly wrung out of a 1:1000 bichloride solution, is placed, with a small amount of boracic-acid ointment (twelve and a half per cent. boracic acid in cosmoline) spread on it just over the wound. Over this a thin layer of absorbent cotton is placed and bandaged on. Such cases report in twenty-four hours, but the dressing is not changed unless it is soiled or there is pain. These wounds usually do perfectly well, but a dressing can be rarely left on more than four days, because it becomes soiled, many patients reporting with bandages almost black. For three months

there has not been a case of cellulitis of the scalp that has arisen while the patient was under treatment, though primary union is not always obtained, in some few cases there being slight suppuration. These wounds are then opened and allowed to granulate.

In wounds of the fingers an effort is made to save as much of the member as possible, and surprising successes are often obtained. Wounds that admit of suture are drained with a few horse-hairs or catgut strands. A dressing similar to that for scalp wounds is applied. The advantage of such a dressing over a dry dressing of either iodoform, iodoform gauze, or bichloride gauze, is that it feels more comfortable, and that when it is removed it comes off without sticking or causing pain, while a dry dressing is usually so firmly held by the slight bloody discharge that it requires some time and much trouble to remove it painlessly. In this dressing we depend upon the bichloride for antiseptis, the boric ointment being used to prevent sticking. Iodoform we do not use in this dressing, knowing that we have a reliable antiseptic in the bichloride of mercury, the only indication for the addition of iodoform powder being to relieve pain. But an aseptic wound causes little pain, hence the iodoform, which is expensive, is omitted.

From this dressing I have seen only one case of eczema, but the majority of our cases are wounds of the hand, in which the skin is tough. In wounds in which there is much laceration, we think it very important, either to make counter-openings for drainage, if there is a large pocket, or simply to pack with moist gauze where this is small.

Divided tendons and nerves are sutured with fine catgut, and many excellent results follow. Ether is given in these cases, as a rule, for before operating it is often impossible to know how extensive a wound must be made. A heavy dressing is applied, and a splint to keep the parts at rest in extension or flexion, as the case requires.

Cellulitis has developed while the patient was under treatment very rarely, in only two cases in three months; but a small number apply for treatment with cellulitis already well marked. The history in these cases, almost always is: "I did n't think it would amount to any thing, and went to the druggist, who put this bit of plaster on." Too much cannot be said against applying

strips of plaster to fresh wounds. If a bandage is not needed, we put a small compress of gauze over the wound, and hold this in place by means of plaster. If a cellulitis is just starting, and there is very little tension, or no particular point of pain, the original wound is opened, thoroughly washed with 1 : 1000 bichloride solution, and the parts then wrapped in a large compress wrung out in 1 : 40 carbolic acid, a piece of rubber tissue placed over this, and a bandage applied, leaving one end open so that the patient can, from time to time, pour on a small amount of the carbolic solution. The carbolic solution is preferred to bichloride, as the latter, applied as a wet compress over a large surface, is very apt to cause an eczema. From the carbolic-acid solution I have seen three cases in three months in which large blebs formed, and the epidermis was loosened from a large part of the hand, but this accident is very rare. For women and children 1 : 60 carbolic solution is used. If the cellulitis has gone further, and there is evidence of pus, or there is much tension, incisions are freely made. Where possible, counter-openings are made, and a small rubber drain inserted. The treatment of cellulitis is considered of the greatest importance, and free and early incisions are demanded in the interest of the patients. We never wait for distinct fluctuation, or "pointing."

In the treatment of this trouble cocaine is of the greatest value, and, when properly used, always gives admirable results—that is, injected *into* the skin (*not* beneath it) at the point of incision, or beneath the skin on the proximal side of the point to be incised. For example, to open an abscess on the palmar surface of the distal phalanx, inject about ten or fifteen minims *deeply* into the middle of the palmar surface of the proximal phalanx; then wait two or three minutes before making the incision. These points in the use of cocaine were demonstrated to me by Dr. R. J. Hall.

In one case, five minutes after the injection of fifteen minims of cocaine about the elbow, the patient vomited freely, and three or four others have complained of nausea or faintness after the use of from fifteen to twenty minims. As many patients faint when they first come to the dispensary, either from looking at their own wounds or those of others, it is not easy to know how much effect cocaine had in producing the faintness in these cases.

When wounds are granulating, balsam of Peru on strips of gauze is found to be very valuable in stimulating granulations. Nitrate of silver is sometimes, with advantage, alternated with this. If there is an offensive odor from a sloughing wound balsam will speedily destroy it.

Particular attention is required to prevent granulations from becoming excessive, and when they tend to grow above the cicatricial edge they are removed with a pair of curved scissors, which can be done without causing pain. This is much better than attempting to keep them down with caustics. The bleeding is stopped by pressure, and the ulcer then strapped, if the skin about it is healthy, or small pieces of rubber tissue are placed across the wound, and held in position by a dry compress and bandage. For this purpose rubber tissue is nearly as good as green protective, and much cheaper.

Burns are treated at first with iodoform ointment (twelve and a half per cent. of iodoform), if not too extensive (as on a hand and wrist); later with an ointment of starch 25 parts, oxide of zinc 25 parts, salicylic acid 3 parts, and cosmoline 50 parts. Some cases do better under powdered subnitrate of bismuth.

Sprains are treated at first with iodoform ointment, spread on gauze, which is covered with common cotton, *firmly* and smoothly applied. If at the wrist, a dorsal splint is used. Iodoform certainly relieves pain in these cases very much. The part is kept at rest about four days, and then, if pain persists, or there is much effusion, Paquelin's cautery is lightly applied, and the part bandaged after rubbing on a little vaseline. The cautery is used at a dull red heat, and applied so as to produce a uniform redness over the joint, and should leave almost no scar. Iodine ointment (U. S. P.) is used sometimes, as a counter-irritant, and to hasten absorption. The tincture is rarely used, as it soon produces a hard, thick layer, so that the next application produces no effect on the parts beneath. We find the actual cautery, as used above, produces excellent results in strains of the back, old contusions, and, especially, in teno-synovitis crepitans of the extensors of the hand when combined with rest.

Of ulcers of the leg many are syphilitic, and in these constitutional treatment is the chief measure in producing a cure. In chronic, indolent, and varicose ulcers every

effort is made to promptly place the ulcer in a healthy condition. If the granulations are pale, flabby, and above the surface, they are cut down with scissors and the ulcer strapped for a few days with yellow adhesive plaster. If the base of the ulcer is below the level of the surface of the skin, presenting the "mucous appearance," it is scraped with a sharp spoon and dressed with balsam of Peru. If the skin about the ulcer is eczematous, an ointment of iodoform or boracic acid is applied. These last cases do better when given moderate doses of iron and quinine. At present the following treatment is being reintroduced, as a few years ago it was used here with success. The surface is washed with 1:40 carbolic-acid solution and covered with narrow strips of rubber tissue which have been dipped in the same solution. Then a large compress wrung out in a saturated solution of boracic acid is applied; over this, rubber tissue and crinoline bandage are added, and the dressing is left on from four to eight days.

Patients with varicose veins are advised to wear Martin's bandage.

Chancroids with an active erosive tendency are treated by cauterization with nitric acid and 95 per cent. carbolic acid. The latter causes only slight pain and anæsthetizes the part, but is often too superficial in its action, and nitric acid is then applied to the sore, which is dried and dusted over with iodoform powder, and a piece of absorbent cotton packed into the ulcer. The patient is instructed to wash the parts about the sore daily with water, and then dry them thoroughly before applying iodoform and compress. Chancroids which are simply indolent are touched with cupric sulphate and then dressed, as before mentioned, with iodoform.

Chancres are not cauterized or excised. An "expectant treatment" is followed until the eruption appears, when mercury is given by inunction, the ointment or oleate being used. The stomach is thus undisturbed, and tonics, usually indicated, are readily taken and well borne. When the inunctions are commenced the patient is made to use a tooth-brush and castile-soap to keep the teeth clean. In addition a gargle of chlorate of potash is given. Unless the precaution of cleanliness is observed the gums soon become tender and bleed readily, but with it these symptoms rarely develop.

The majority of patients being forced to

keep at hard work no attempt is usually made to abort a bubo. In some few cases when rest can be obtained pressure is applied, and in a majority of cases suppuration is avoided. As soon as there is redness and much pain in the bubo, an incision is made without waiting for signs of fluid to appear. The incision is made after the injection into the skin of cocaine, and very little pain is felt. The incision is a free one, parallel to Poupart's ligament, and opens the whole of the tissues involved. The finger is then introduced into the incision, and the spongy mass thoroughly broken down and enucleated, a steel curette being frequently needed when the mass is firm. To open freely the pockets on either side of this cut several others are made at angles to the primary incision. The bubo is then packed with iodoform gauze and heals by granulation.—*Medical News*, Feb. 26, 1887.

On Rupture of the Urinary Bladder.

—In *The Lancet* for December 11, 1886, Sir William MacCormac reports two cases of this traumatism treated successfully by laparotomy and suture of the vesical rent.

During ten years only seven cases of rupture of the bladder have been admitted to St. Thomas' Hospital, and the writer says this form of injury is also rare in France, Germany, and Austria.

In 1862 Dr. Walter, of Pittsburg, Pa., opened the abdominal cavity for intraperitoneal rupture of the bladder, sponged out the blood and urine, discovered the rupture but did not suture it. He closed the abdominal wound, introduced a catheter into the bladder and the patient recovered.

This case and the two now reported seem to be the only ones on record of recovery from an indubitable *intra-peritoneal* rupture of the bladder, it not being clearly stated whether Hafmoki's¹ case was of this variety. The first case was that of a man, aged thirty-three, who, fifteen and one half hours before admission to the hospital, ran with much force against an upright iron post, its head striking him in the region of the umbilicus. He fell down, but soon recovered and walked home. He said he had passed his water about an hour and a half before the accident, but had been drinking beer. Soon after receiving the injury he vomited twice and attempted to micturate. During the night he had much pain and fre-

quent unsuccessful attempts to pass water. The following morning he walked unassisted about a mile to the hospital.

On admission patient complained of much abdominal pain. He was unable to pass any urine. There were no symptoms of shock. Abdomen was distended and exceedingly tender, especially in the hypogastric and epigastric regions. There was resonance anteriorly with dulness in both flanks, varying in extent with the position of the patient. One and one half ounces of bloody urine were drawn off, and about two hours later, on again introducing the catheter, ninety-five ounces of slightly red colored fluid were drawn off, giving patient much relief. Temperature 99.8°, respiration 24.

Ether was administered, the abdomen was opened by a median incision about six inches long, terminating just above the pubes, and a rent about four inches long was discovered in the bladder, extending from the superior fundus to the recto-vesical cul-de-sac.

This wound was closed with sixteen silk sutures, introduced, as in the Lembert intestinal suture, through the serous and muscular layers only. In addition, eight catgut sutures were passed through the peritoneum only, at points not perfectly closed by the silk suture.

The bladder was then moderately distended with a weak solution of boric acid and found water-tight. The abdominal cavity was washed out with a similar solution, a glass drainage-tube was inserted through the abdominal wound, which was then closed with silk sutures. A catheter was tied in the bladder. The patient did perfectly well, and on and after the third day passed his urine naturally. He was sent home cured within two weeks.

The second case was a man, aged thirty-seven, who fell a distance of twenty feet, striking in a sitting posture on some soft clay. One half hour before the accident he had micturated, and at about the same time had drunk a pint of beer. He did not have at any time any symptoms of collapse, and drove in a cab to the hospital. There he was carefully examined and only a bruise of the buttocks discovered. He did not complain of abdominal pain or a desire to micturate, so no catheter was passed, and he went to his home. During the next four hours he began to have abdominal pain and a strong desire to pass urine but was unable to do so. He did not vomit.

¹ *Wiener Med. Presse*, Sept., 1886.

Twenty-four hours after the injury had been received he drove to the hospital again and was admitted. Six ounces of turbid coffee-colored urine were drawn off. His symptoms were almost exactly the same as those of the first patient. In this case, however, no large amount of urine was drawn off.

The patient was given ether and the abdomen opened as in the first case, disclosing an irregular obliquely placed rent in the bladder, situated at the upper and posterior part, slightly to the left of the middle line. It measured two inches in length on the peritoneal surface and only one quarter of an inch long on the mucous surface. This wound was closed with twelve silk sutures introduced as in the first case.

In this case a glass tube was not placed in the abdominal wound and a catheter was not tied in the urethra.

On the third day he had complete control of his bladder, and was well in two weeks.

In concluding, the author says, although there may be many cases where certainty of diagnosis is difficult to arrive at, yet the group of symptoms usually associated together, taken with the history of the injury, is in the majority of instances sufficient to render a correct diagnosis reasonably certain. Moreover, the only manner in which an uncertain diagnosis can be made certain is by practising an exploratory laparotomy, which he urges should be done early in the case.

Dr. R. F. Weir describes in the *Medical Record*, January 22, 1887, a very satisfactory and reliable method of ascertaining whether the bladder has been ruptured, which he had recently employed at the New York Hospital. A large packing-box had fallen upon the patient, and when brought to the hospital bloody urine was drawn and a fracture of the ascending ramus of the ischium discovered.

There was dulness for a short space above the pubic bones and elsewhere slight tympanites. The patient was etherized and Peterson's rubber bag, covered with a silk net to prevent over-distension, passed into the rectum, a rubber catheter having previously been introduced into the bladder. The bag was then filled with seven and one half ounces of warm water, and the line of supra-pubic flatness marked out with an aniline pencil. Seven and one half ounces of warm carbolic-acid solution,—one to one

hundred,—were then slowly introduced into the bladder, when the contour of the viscus could be felt above the line previously marked out. The solution in the bladder was then allowed to escape, and on being measured was found to equal in amount that introduced into the bladder.

The patient was not operated upon, as it was considered that there was no rupture of the bladder, and he made a good recovery. This test is easy to make, and, if properly applied, so as to avoid over-distension, is safe and reliable, and would probably be preferred by the majority of surgeons to an exploratory laparotomy, the patient and surgeon each being prepared for an immediate operation should the test indicate one.

The following case reported by Dr. W. H. Parcels in the *Medical and Surgical Reporter*, February 12, 1887, seems to have been one in which Weir's test would have at once settled the fact of a rupture had it been suspected. The patient, a man, when first seen said that for five hours he had not been able to pass any urine; for fifteen hours preceding that time had been able to pass but a tablespoonful at frequent intervals. During this time he had "made a trip" of six miles. He complained of severe abdominal pain, had slight fever, and a small, hard pulse. At this time no history of an injury could be obtained, but twenty-four hours before his death it was ascertained that he had been on a spree with three "girls of easy virtue," who, among other things, "tramped upon his abdomen."

There were no evidences of a distended bladder, but an unsuccessful attempt was made to pass a catheter. The writer then states: "I concluded to defer the operation [of catheterization] until morning, inasmuch as I could not satisfy myself that the bladder was at all distended.

"The following morning I found no urine had been passed yet, and he said he had no inclination in that direction, though the lower part of the abdomen was greatly distended now. With finger in rectum, I succeeded in introducing the catheter, but, to my surprise, I could only draw off a couple of ounces of urine."

A few hours later another unsuccessful attempt was made to introduce a catheter, after which, to quote again:

"The swollen condition of the abdomen above the pubes, and the intense pain and

tenderness, and last but not least the fact that no significant amount of urine had been passed for about thirty hours, argued in favor of puncture of the bladder. With a curved trocar I performed the operation per rectum, but was again surprised at the small amount of urine we got. Further efforts to introduce the catheter were unsuccessful, a few drops of urine coming away, and the instrument was left in place."

The patient gradually sank and died in forty-eight hours. The autopsy showed a rupture in the upper portion of the bladder on the left side, with peritonitis. The author concludes as follows:

"Had we known that the bladder was ruptured, could we have done more than we did? I say, yes; we could have performed abdominal section, which I think is the surgeon's duty in such a case after he has made a *positive* diagnosis."

In the *British Medical Journal*, February 26, 1887, Mr. Henry Morris reports the case of a man who when thirty-six years of age, in June, 1879, during a struggle, was thrown down, and his opponent then knelt with violence on his abdomen. He was admitted to the hospital under the diagnosis of rupture of the bladder and peritonitis, where he was treated by hot fomentations to the abdomen, opium, and the fixation of a catheter in the bladder. He recovered perfectly. August 4, 1886, he was again admitted to the hospital. Two days previously he had attended a "bean-feast," and on the following morning he had some pain while micturating, and this pain continued during the day, and at night he could pass no water. He was admitted as a case of peritonitis with suppression of urine, and died two days later.

At the *post-mortem* recent general acute peritonitis was found, and in the pelvis there were fifteen ounces of purulent urine and a quantity of lymph. A band an inch and a quarter long united the fundus of the bladder with the rectum. The vesical end of this band was hollowed out into a slender funnel, and through a rupture in it close to the bladder a string of mucus was projecting. Slight pressure caused purulent urine to ooze from the bladder through the rent into the peritoneal cavity. The rectum, bladder, and penis were removed *en masse*, and were submitted to a committee consisting of Mr. Savory, Mr. Bryant, and Drs. Goodhart and Kingston Fowler, who reported that in their opinion "the specimen

exhibits all the features which might be expected at a remote period after a rupture of the bladder." This case, in the first instance, had been reported in 1879 as one of recovery from rupture of the bladder. It was now brought before the Society, because in its completed form it afforded conclusive proof that an intra-peritoneal rupture of the bladder was not necessarily fatal, but may be recovered from under the simple treatment employed in this case, provided the urine at the time of the rupture is of normal composition. The case was believed to be unique, in that it furnished the *post-mortem* appearances of the bladder some years after recovery from an intra-peritoneal rupture of its coats.

The cicatrix had given away seven years after the first rupture, causing the fatal peritonitis. G. B. P.

THERAPEUTICS.

Suquet on the Therapeutic Use of Iodol.—It is chiefly in the treatment of ocular affections that the author has employed this new drug. In wounds of the lids he finds it an excellent antiseptic; also in ulcerations of the lids, whether primary or consecutive to disease of the lachrymal ducts. As an ointment it is useful in impetiginous eczema of the cutaneous surface of the lids.

In chronic, torpid forms of conjunctivitis it is indicated, but in acute irritative conditions, as simple blepharitis and acute conjunctivitis, it is contra-indicated.

In chronic affections of the lachrymal ducts, purulent dacryocystitis, and osseous lesions treatment by iodol gives good results.

In bad ulcerations of the cornea, primary or secondary, and in corneal wounds, iodol is an efficient antiseptic.

Iodol has one great advantage over iodoform in having no odor, or if it has one it is very weak, rather agreeable, and resembling thyme. It has the disadvantage of being rather insoluble, dissolving only in 5,000 parts of water. It is four times as expensive as iodoform. It contains a large percentage of iodine, and, according to the author, acts by the contained iodine being set free a little at a time under the influence of heat and the products of inflammation. It can be used in powder, in alcoholic, ethereal, or collodion solution, in an ointment with vaseline or camphor and vase-

line in crayons or volatilized.—*La Thérap. Contemp.*, Feb. 4 and 11, 1887.

Ogg (R. T.) on the Subiodide of Bismuth as a Substitute for Iodoform for Local Applications.—For several years I have been trying to find a substitute for iodoform in the treatment of chronic ulcerating surfaces, as well as for fresh wounds, and from the good results obtained by the use of subiodide of bismuth, as claimed by Dr. Reynolds,¹ of Philadelphia, I was constrained to give this comparatively new drug a fair trial.

The first case in which it was used was that of a very anæmic and debilitated young man, suffering with chancroidal ulcerations of the integument and glans penis, and of the raw surface left after having been circumcised by another physician two weeks previous to his coming to me.

The integument of the whole circumference of the penis for an inch and a half behind the corona and three sores of small area on the glans were suppurating profusely. The œdema that was present gave the organ the appearance of twice its normal size. There were no distinct signs of a phagedenic character. After a thorough cleansing of the parts with a weak carbolic solution, the subiodide of bismuth was thickly sprinkled over the ulcers and the organ enveloped in carbolated cotton. His instructions were to cleanse thoroughly and make applications twice daily and to keep the organ elevated.

At the expiration of ten days not a single spot of ulcerated surface could be seen. The newly formed skin was of course delicate and easily abraded, but in other respects seemed healthy. The œdema was partially relieved. With no other treatment the case continued to improve, and at the expiration of three weeks was completely cured and had remained so for two months afterwards—the last I saw of him.

A hard, single bubo in each groin received daily applications of tincture of iodine and never suppurated. The area of diseased tissue was so great as to preclude the use of a strong caustic. The application of subiodide of bismuth sometimes causes a slight stinging pain for a few seconds, similar to that which follows iodoform in powder or in other solutions.

I have used this preparation of bismuth in the treatment of quite a number of cases of non-specific as well as specific ulcerations, and so far have found it to be a drug of superior potency. When used as a packing for cavities that remain after the evacuation of pus from small abscesses, such as buboes and suppurating glands in other parts of the body, I don't think it equal to iodoform or tincture iodine.—*Kansas City Med. Index*, Feb., 1887.

Antiseptic Vandals.—If there be one antiseptic agent more than another which has made rapid strides into public favor, and this notwithstanding a penetrating and disagreeable odor, that agent is iodoform. For some occult reason, possibly connected with its chemical formula, it was elected to the freedom of the corporation of barber surgeons in all the countries of Europe. It has become a universal favorite in the treatment of every thing, from a dog-bite to a chancre. This is the moment that certain individuals of ill omen have selected to insinuate doubts as to its antiseptic powers. "'T was ever thus in childhood's hour . . . I never loved a bird or flower, but 't was the first to fade away." The poet, it is true, was not alluding to iodoform, but his plaintive language is very appropriate under the circumstances. The attack on iodoform is only part of a conspiracy against antiseptics in general. A gang—for they hardly deserve a better title—of scientific men, regardless of the alleged good effects which have followed their use, have undertaken to show that these good effects are in no wise attributable to the disinfectants and antiseptics on which we have relied to soothe our declining years. With the utmost disregard for our feelings, they openly laugh at the polished copper spray producer, and sneer at the admirable arrangement of our antiseptic dressings. They care nothing apparently for the *mise-en-scène* which their employment affords, and they cruelly insist that all is vanity. If their infamous designs be accomplished, it will only remain for us, metaphorically speaking, to hang our harp on the willow trees and weep the departed glories of antiseptic surgery.—*Med. Press*, Feb. 23, 1887.

Wilcox (R. W.) on Naphthalin.—Since reading Rossbach's paper in the *Berliner klinische Wochenschrift*, in November, 1884, we have used naphthalin in thirty-two cases, all adults with few excep-

¹ See MEDICAL ANALECTIC, 1886, p. 491.

tions. The most frequent cause of failure has been the use of too small a quantity, less than sixty grains daily being a needless waste of a very good medicine. We have given even one hundred and twenty grains per day, in divided doses, usually in starch capsules with a little oil of bergamot to conceal the rather unpleasant odor of the drug. If the drug be carefully washed with alcohol I have never met the second cause of failure, viz., the development of untoward symptoms. Frequently the urine becomes smoky, resembling the urine of acute nephritis, but a careful examination failed to detect either casts or albumen.

In chronic diarrhœa naphthalin has been the only drug used in twenty-three cases. Nearly all degrees and all varieties except the diarrhœa of tuberculosis, have been represented. Some could be traced back to a cholera morbus of the preceding summer; others were the results of improper food or followed debilitating diseases. All the cases were relieved in periods of from one week to two months; generally about ten days were sufficient for a cure. It is useless to multiply cases, for the history of one is about the history of the rest.

James D——, eighteen years old, a messenger, came to me complaining of a diarrhœa of over two years' duration. Its commencement was in the second summer before he was seen for the first time, and the cause assigned was over-indulgence in unripe or spoiled fruit. The disease had continued through the succeeding winter with intervals of cessation and was aggravated the following summer. Since summer his loss of flesh, previously considerable, had increased, his tongue was coated, his appetite poor, his discharges were five or six daily, unformed, varying much in quantity, sometimes watery, very foul-smelling, troubled greatly with gas, but there was no tenesmus, no blood; pain at times, but no fever. Altogether he was in a deplorable condition, and so long as his work remained severe and his food unsuitable, it did not seem possible that he could be benefited. He took sixty grains of naphthalin daily, and within a week the number of movements were reduced to two daily, and for the first time in two years became formed and devoid of odor. About six months afterwards he reported that after three weeks he had discontinued his medicine as there had been no further need for it.

In chronic dysentery I have used naphthalin in seven cases with excellent results. The most noticeable case was that of James C——, sixty-six years old, who contracted dysentery while serving in the Federal army in 1862 to '64. He had never been free from the disease, except for a few weeks at intervals. He could remember no day during which he had not had more than one passage. He was emaciated, with sallow, dirty skin; suffered from marked tenesmus; abdomen very painful on pressure; no appetite. His stools averaged seven daily and were slimy, blood-stained, of extremely foul odor. This man had ninety grains of naphthalin daily, and at the end of a month he would barely have been recognized as the same man. Four months later he reported himself so much improved that he considered himself a well man.

My experience in the diarrhœa of typhoid fever has been limited to two cases, Chas. B. and John F., whom I saw for the first time in the third week of the disease, the diagnosis being firmly established. In both there were commencing tympanitis and diarrhœa to the extent of six to ten motions in the twenty-four hours. Naphthalin was administered, sixty to ninety grains in the day, with the result of "stiffening up" the discharges and reducing them to two daily. The odor of the stools in both cases was destroyed by the use of the drug. In fact, so confident was I that the intestinal canal, and consequently the fæces, were thoroughly disinfected in the body that I did not direct any other disinfection.

In passing I wish to call attention to the antipyretic effects of the drug. In general, the use of antipyretics in typhoid fever I consider unsafe, but if the practitioner is thoroughly imbued with the idea that he must use an antipyretic, let him use naphthalin, which reduces temperature, indirectly, by disinfection of the intestines. Its absolute safety will compare favorably with thallin, antipyrin, and antifebrin. Whether typhoid fever has ever been abated by this or any other drug I am unable to say, but if such can be done, it seems that naphthalin would be as likely to accomplish this as any at our disposal. Of the use of naphthalin in acute intestinal catarrhs as well as in the intestinal catarrh of children, I have had no experience. In all my twenty-three cases of chronic diar-

rhœa I was able to exclude tuberculosis as a cause, while all of my tubercular cases have been free from diarrhœa, so that I can not, from personal experience, indorse Rossbach's recommendation.

I would emphasize the claims of naphthalin in all cases where it is necessary to disinfect the intestinal canal or in typhoid fever, intestinal indigestion and catarrh, chronic diarrhœas and dysenteries, because I believe its comparative insolubility gives us only a local action. It has proved to be a vigorous antiseptic, and its use, unlike that of corrosive sublimate or of resorcin, is entirely devoid of danger.—*St. Louis Med. and Surg. Jour.*, March, 1887.

Laure on the Dangers of Santonine.—A mother gave a three-and-a-half-year-old child a grain and two thirds of santonine. The next day Dr. Laure was called. The child was lying on its back profoundly prostrated, crying now and then in a croupy way, flexing the thighs and carrying the hands to the abdomen as though it was the seat of pain. The attack over, the child fell back in a state of somnolence. The face had a livid pallor, the eyes were sunken, and the pupils dilated. The respiration was rapid, and the pulse was quick and irregular while the rectal temperature was subnormal. The belly was tense and tender, vomiting frequent, and the stomach intolerant of food. The mother said that the child had the night before passed bloody urine; but this the doctor thinks was simply urine discolored by the poison.

There was complete anuria for ten or twelve hours.

The treatment consisted of milk, rum toddies, laxative injections, and poultices on the belly. The secretion of urine became reëstablished, the tympanitis disappeared after several free stools, and gradually the vomiting ceased, and the child promptly recovered.

A sister of the child, three years older, had xanthopsia two hours after the ingestion of the drug, but no further inconvenience.—*Lyon Méd.*, Feb. 6, 1887.

Milk Diet.—The therapeutical advantages attending an exclusively milk diet in the treatment of certain diseases have received general confirmation, but like most other remedies, its employment requires certain precautions to be adopted if the good results are not to be obtained at the expense of some other ailment. It

has been recently pointed out that the ingestion of more than two quarts of milk daily for more than a short period of time, is likely to cause dilatation of the stomach, with the whole train of distressing symptoms to which this gives rise. It is advised that where larger quantities than this are required to be taken, in order to keep up the nutrition, it is preferable to administer small quantities of meat together with small doses of an alkaline base after each ingestion. If the contents of the stomach be kept neutral, digestion takes place only in the intestines. If it be desired to avoid giving meat, the milk should be strengthened to the required degree by the addition of concentrated milk or evaporation. Not unfrequently means have to be adopted to aid the digestion of the lumps of agglomerated curd which form when the milk enters the stomach, and the size and consistency of which delay and interfere with the action of the gastric juice. The only remedy for this is pre-digestion by means of the pancreatic ferments, many good preparations of which are now in the market.—*Med. Press*, Feb. 9, 1887.

Minges (Geo.) on the Treatment of Croup with Digestive Sprays.

I have treated sixteen cases with inhalations of solutions of one or the other of the digestive ferments, thrown in a spray by a steam-atomizer. The list includes sporadic, sthenic cases, as well as those of an asthenic nature, secondary to diphtheria of the fauces, and one secondary to measles. Two successful cases in which I at the time diagnosed croup below the vocal cords, I have decided to ignore in estimating the results of treatment, having probably misinterpreted the phenomena, although Gerhardt states that all the symptoms may be absent in diphtheritic laryngitis, while they may be present in other diseases causing laryngeal stenosis. One fatal case I must also exclude, patient having been in the asphyxic stage when treatment was begun.

I claim no originality, but think I have used digestive sprays since a time when they were but little mentioned in current literature. About five years ago I read somewhere that Rossbach (?) was using a spray of papayotin solution to dissolve false membranes. I utilized the principle in the first case of croup, and that a bad one, coming under my treatment, but substituted pepsin for the expensive papayotin,

and as patient recovered, I have used the method ever since, but of late in a modified form.

The mixture was prepared by adding grs. x Jensen's pepsin, dissolved in glycerine, to Oj water, and acidifying with $\frac{3}{4}$ ss lactic acid. This solution, thrown into a spray by a steam atomizer, was directed towards the child's mouth and nostrils continuously, day and night, until the worst danger seemed over, generally about a week, and after that during the nocturnal exacerbations for about a week more. Of course, it is not probable that much of the fluid reached the larynx, but it is an open question whether pepsin acts by its quantity, or only in a catalytic manner. Dr. H. D. Chapin has shown by experiments with trypsin solutions, that the spray dissolves membranes relatively more quickly than immersion.¹ The person using the atomizer must be constantly on the alert to follow any movement of the patient's head and keep the spray playing on the mouth and nostrils; the child then becomes restless, opens its mouth to cry, takes a deep inspiration, and the cough proves that the fluid enters the larynx. Any one can satisfy himself of this by trying it on himself. Children, after a short time, do not mind the spray much, and in all except the most fulminant cases the relief has been marked and prompt. The child usually soon falls asleep, and at this time the spray can be used continuously without trouble. It is doubtful whether any of the fluid enters the respiratory passages during sleep, but the steam alone must do considerable good. If the dyspnoea again increases, the child awakes, and, if necessary, can be made to breathe through its mouth for a while. Other children sometimes ask for the spray, and one (case 8), even for some time after full recovery, could be put to sleep only when the "little stove" was burning beside his crib.

If the membrane form again faster than it can be digested, the relief is only temporary, and after the stenosis has become extreme, there is not enough air current through the trachea to carry the spray where it is needed, but after the performance of tracheotomy or intubation of the larynx per os, digestive sprays ought to be of immense benefit.

One drawback of the acid pepsin spray is that it causes considerable erythema, and sometimes swelling, of the face. This can be avoided to a certain extent by anointing the exposed surfaces with cosmoline and covering the eyes with a cloth. In my last four cases I have obviated this difficulty by substituting an alkaline pancreatic solution, prepared as follows: R. Ext. pancreatis (Fairchild Bros. and Foster's) 3 j; glycerine, q. s. ut. ft. sol.; nat. bicarb., 3 ij; sol. thymol (1:1000), $\frac{3}{4}$ iv. (to prevent decomposition of the ext. pancreas, which occurs very quickly); aquæ, q. s. ad. Oij, filtered. These solutions I have used in large quantities, generally a quart during the day, and an equal quantity at night, and sometimes much more. Perhaps their strength could be increased with advantage.

Dr. Chapin describes a hand-ball atomizer with tongue-depressor, combined in one instrument, by means of which a concentrated solution of ext. pancreatis, gr. xv.: $\frac{3}{4}$ j, can be thrown more directly into the larynx for a minute or so every fifteen minutes.¹ In severe cases this might be occasionally used together with the constant spray from the steam-atomizer. I have never had any trouble in getting parents to persevere with the treatment, but in one case, where, after the child had materially improved, even at night, the suction tube became stopped soon after my morning visit, by the scum always present in the pancreatic solution, and by evening the child was past all hope. I had explained to the parents how to cleanse the tube with a small feather from the large end, but, not being very intelligent, they failed in their attempts.

In New York they use a trypsin-spray, and according to Dr. B. M. Van Syckel, this ferment can be extemporized as follows: Add 5 grammes (3 j grs. xvij) ext. pancreatis to 500 cc. ($\frac{3}{4}$ j 3 vi) of a 1-per cent. solution of salicylic acid, and digest in a water bath at 37° C. for four hours; filter, and make slightly alkaline with bicarbonate of soda.²

Now as to my own results. Before I began to use the treatment above described, I had three cases of croup, all fatal; but they were all very severe and apparently

¹ *Medical Record*, vol. xxvii., p. 257, March 7, 1885.

² *Medical Record*, vol. xxvii., p. 257.

³ *Medical Record*, vol. xxvii., p. 207, Feb. 21, 1885.

infectious, two occurring in families in each of which another child died of the same disease, either just before or soon after, and the third in a girl of fifteen, convalescing from typhoid fever, infected by a brother with diphtheria.

Of the thirteen cases which I will utilize in estimating results, six recovered. All of these ran a slow and protracted course, and hence gave the treatment some chance to succeed. Of the seven fatal cases, all but one ran through the different stages very rapidly. Of seven cases where a distinct membrane was seen in the fauces, three recovered. Loomis says: "When the diagnosis is based upon the presence of the membranous exudation in the tonsils and epiglottis, recovery seldom occurs.

I have tried to compare my results with those of others reported in the Dubuque Health Office. I will select the report of the health physician for the year ending February 28, 1883, as the disease was then rather prevalent, and hence more liable to be fatal, and errors of diagnosis less likely to occur. During that year there were reported 37 cases of croup, with 21 deaths. Of these, 32 were treated by other physicians and by methods unknown to me, with 19 deaths, a mortality of 60 per cent.; 5 were treated by me as above described, with two deaths, a mortality of 40 per cent. Of the cases which recovered, one occurred during convalescence from measles, when, according to Steiner, true croup is much more common than false, while the reverse holds true in the beginning of measles.

Both Steiner and Monti lay stress upon the rarity of recovery from croup occurring in the desquamative stage of measles, the latter never having seen one get well. In the second case the extensive pharyngeal exudation, which had been seen by the mother, had disappeared when I was first called, but the submaxillary glands were much enlarged. The third case may have been one of severe spasmodic croup, although the long duration of the prodromal stage (four days), the first occurrence of suffocative attacks at noon, the severity of the symptoms, and the slow recovery, speak rather for pseudo-membranous obstruction. Of the fatal cases, the first was fulminant, and time was lost by treating it at first for spasmodic croup; in the second the treatment had a pretty fair trial, but failed to save the patient.

I would urge physicians to give the

digestive ferments a fair trial in conjunction with such other treatment as the individual cases may demand. If it would seem impossible for the extract of pancreas or trypsin to have any solvent action in the small quantities inhaled in this way, how much more inert must be the lime-water spray used in the same manner, and if the former be not more active than the latter, it has at least the virtue of being equally harmless. Should any one, stimulated by this report, devise a readier means of bringing the digestive fluid in contact with the false membrane, making the method applicable also to fulminant cases, and doing away with the reckless and dangerous doses of mercury now in vogue, the object of this paper will be accomplished.—*Four. Am. Med. Ass'n*, Feb. 12, 1887.

Grant-Bey (J. A. S.) on the Employment of Mercury in Parasitic Contagious Diseases, More Especially the Use of the Bichloride in the Treatment of Diphtheria.—Mercury and its preparations are a parasiticide, and some of these preparations are more so than others.

The bichloride is, perhaps, the most potent, and is perfectly safe when intelligently used, and I should advise its being tried in all infectious or contagious diseases in preference to other preparations of mercury. Its well-known action in preserving the red globules of the blood intact is, no doubt, owing to its killing the bacteria that would otherwise cause their disintegration.

The biniodide is preferred by some physicians, and many who acknowledge the efficacy of other preparations of mercury still hesitate to employ the bichloride. As yet I have met with no untoward symptoms in using it; but should colic or irritation of the large bowel set in, then it ought to be suspended, at least for a time, and smaller doses given afterward.

In my last case of diphtheria, I am convinced that the natural detachment of the membrane favored the absorption of the drug, and thus also its curative action; and although I am averse to the forcible tearing away of the membrane, yet, without doubt, many bacteria are protected by it that we ought to endeavor to get at with as little annoyance to the patient as possible.

To effect this, it seems to me that the best method would be to employ some of the ingredients that are known to have a solvent effect upon the membrane, and

these to be applied by means of spray, when the patient can neither gargle, nor drink, nor allow the throat to be touched.

We have all, no doubt, tried the effect of lime-water, as well as that of lactic acid, in this respect ; but have we tried them with the addition of corrosive sublimate ?

Of late "papayotin" has been in vogue in Germany as a remedy for diphtheria ; but from the cases I have seen reported its action seems to me to be very decidedly solvent and nothing more. Still, that is a great matter when so many cases die of suffocation from the presence of the membrane.

Papayotin is prepared from the juice of the trunk and fruit of the South American melon-tree (*Carica papaya*).

It is innocuous when taken internally, but when injected into the blood it paralyzes the heart and nervous system.

It must not be used, therefore, without certain precautions. I should be very chary in applying it to a bleeding surface.

Its local application prevents the fibrinization of the serosity thrown out by blood-vessels on any surface, whether on a mucous membrane or on an abraded skin, but the living, healthy mucous membrane is not affected by it.

Weak solutions of it have no solvent effect. About one to six is the average strength to be used, and may be applied to the part affected by converting it into spray by means of a brush, by gargling with it or drinking it, and two or more of these methods may be combined if considered necessary or desirable, and persisted in every hour till the membrane is dissolved or obliterated, which will be the case, probably, after eight or even fewer applications.

In my opinion papayotin merely digests the membrane (just in the same way as the gastric juice digests the fibrinous material in our food), and may or may not have any parasiticide action whatever. I have not the slightest doubt, however, that it forms an excellent adjuvant to the bichloride treatment of this formidable malady.

Syringing the nose with the antiseptic solution of the bichloride should not be neglected, as in this way the upper part of the pharynx comes under the direct influence of the remedy ; while, if the false membrane has already been formed there, the papayotin may be applied to dissolve it away.

When the patient is not able to swallow, or refuses to take nourishment, and is very prostrate, I give enemata every four hours, consisting of about four ounces of strong beef-tea, with twenty drops of brandy. When milk can be taken, I prefer it to all other kinds of nourishment, and I generally add to it about one third aqua calcis.

The following are the usual precautions I adopt in all diphtheritic cases :

First. Isolation of those who are not required to attend upon the patient.

Second. Thorough and constant disinfection of the whole house, but sick chamber and water-closets in particular.

For this purpose I use towels saturated with crude carbolic oil, and hang upon towel-racks or on any other suitable thing.

Third. Attendants are made to gargle their throats now and again with some disinfectant, or even with salt water.

Fourth. Chamber utensils are also disinfected.

I have also thought (although I have not as yet carried it into practice) that it would be a good precautionary measure to put both attendants and those who have been isolated on a mild bichloride régime as long as there was any danger of the appearance of the malady that might be still in its incubative stage.

I claim for the bichloride treatment this great advantage, that besides giving better results than other remedies the patient's strength is not wasted by those almost convulsive fits that are so frequently induced by the struggles of the patient to prevent the throat from being examined.

The following is the prescription employed :

℞ Hydrargyri bichloridi . . .	gr. jss.
Glycerini	3 j.
Aquæ dest.	3 iij.

with the directions to give a teaspoonful (3 j.) to the patient every half hour till six doses were taken, and then to give it every hour night and day.—*N. Y. Med. Record*, March 5, 1887.

Wilcox (R. W.) on Hydrastis Canadensis in Uterine Hemorrhage.—The author gives of the fluid extract of hydrastis thirty drops, three or four times a day, in cases of fibromyomata, subinvolution, and hemorrhagic endometritis. According to him, it checks the bleeding from uterine fibromyomata by the production of persistent anæmia, unaccompanied by the dis-

treassing cramps of ergot or the flooding from the alternate contractions and relaxations. So in the cases of small fibroids it is preferable where their expulsion would probably be attended by hemorrhage or septicæmia.

In hydrastis he sees a sovereign remedy in endometritis fungosa, even when curetting has failed to arrest the bleeding. He has seen a fatal result from the apparently simple operation of curetting. That there is danger is attested by the number of so-called antiseptic curettes to be found in the market. With the use of hydrastis no confinement to the bed is necessary.

Hydrastis canadensis, by its faithful use, will often render Emmet's operation unnecessary. The uterus becomes smaller, the leucorrhœa diminishes, the erosions heal, the displacements become rectified. Apparently it is to this class of cases that Shvestizenoff refers, although he does not apparently recognize a lacerated cervix.

The author has treated successfully five cases of climacteric hemorrhage with hydrastis.

The results obtained in these cases he regards as admirable, and believes he has a valuable remedy in this class of cases, which oftentimes are very difficult to relieve. It is only fair to say that he has also used the bromides sparingly and arsenic somewhat vigorously, but he feels positive that, in removing one cause of general anæmia, hydrastis has been of great benefit.

Nine cases of pelvic inflammation have come under his care which have been treated with hydrastis, and since using hydrastis he has abandoned the use of iodine, and to some extent hot water and local treatment. He recommends it in pyosalpinx, thinking it reduces hyperæmia without contracting the tubes.

He, in this way, treated three cases of congenital antelexion with marked relief of symptoms.

The author thinks that a timely use of hydrastis may in many cases prevent operations now considered necessary, and also obviate the necessity of wholesale gynecological examinations which, in the case of girls, he rightly deprecates.—*N. Y. Med. Four.*, Feb. 19, 1887.

Villemin on Belladonna and Opium Combined in the Treatment of Acute Diabetes.—The patient thus treated was passing 14. litres of water a day, containing 841 grammes of sugar.

Appropriate diet did not affect the amounts much.

The extracts of belladonna and opium were given in increasing doses until, at the end of two months, the patient was taking 0.15 (gr. 2½) of each, and the water had diminished to 3-4 litres and the sugar to 2-5 grammes. A month later, when taking 0.20 (gr. 3½) doses of the two extracts, the water was reduced to 2 litres, which contained no sugar at all.

Cessation of the remedy or substitution of the bromides caused a speedy reappearance of the sugar.—*La France Méd.*, Feb. 24, 1887.

Jumont on the Indications for and the Method of Using Nitro-Glycerine.—The pulse furnishes the best indication. The more wiry is the radial artery, the more readily will it dilate and the less will the accessory effects of the drug be felt. The fuller and more tense the artery is, the less effect will the drug have, and the weaker and more compressible the pulse is, the more are the accessory effects of the drug felt.

A one-per-cent solution being used in the first instance, the dose should be one drop, in the second two drops, and in the third instance ¼-½ a drop. In the case of women, children, old people, anæmic and nervous patients, very small doses should be prescribed.

Organic heart disease does not constitute a contra-indication for the use of the drug, but in atheromatous conditions of arteries it should be used with caution.—*La France Méd.*, Feb. 22, 1887.

McCord (A. H.) on Veratrum in Puerperal Convulsions.—On the morning of May 19, 1886, was called to see Sallie Mc., negress, aged about 25, multipara, in previous robust health, about seven months pregnant. When I arrived she had had two convulsions; could yet swallow; was blind. I succeeded in getting her to swallow a large dose of brom. pot., chloral hydrate, and sulph. morph. In one hour she had another convulsion, after which she was no longer able to swallow.

I then unloaded her bowels with an enema. Anticipating another spasm in about an hour, I commenced the use of chloroform by inhalation in time to lengthen the interval to an hour and a quarter. The chloroform alone was kept up at intervals for three hours more, with no good

result except increasing the interval a little, without mitigating the severity of the spasms. I then bled her freely, still keeping up the chloroform, which lessened the severity of the paroxysms somewhat. Again, after two hours, I reopened the vein and bled her the second time, with no better result than the first.

About twenty minutes before I was expecting the fifteenth convulsion I gave her hypodermically twelve drops Norwood's tinct. veratrum viride with ten grains hydrate chloral, and the fifteenth paroxysm never came. In forty minutes I repeated the dose with the happy result that there were no more spasms, neither were there any muscular twitchings, nor even tremor indicating the return of the fits. The great arterial tension was speedily relieved, and the pulse slowed to about sixty beats per minute. I then substituted tinct. digitalis for the veratrum, and at intervals of two hours gave the chloral and digitalis until six doses were given. She recovered consciousness in about twenty hours from the last fit.

There was no dilatation of the os nor contraction of the body of the uterus during the whole nervous phenomena, but two days later uterine contractions set up, labor came on, and she was soon delivered of a dead foetus, from all of which she made a speedy recovery.—*Daniel's Texas Med. Jour.*, Feb., 1887.

Teissier on a Spinal Cord in a Case Where Nerve-Stretching had been Employed.—The specimens consisted of sections of the spinal cord of a subject in whom Dr. Teissier had stretched both sciatic nerves.

In sections from the upper part of the cord the microscope demonstrated a rupture of the gray matter, while the white matter had preserved absolutely intact its form and relations. M. Aubert has seen symptoms indicating a traumatism of the cord follow nerve-stretching, while M. Pollosson had seen an acute myelitis follow the same operation.—*Lyon Méd.*, Feb. 20, 1887.

Van Bibber (W. C.) on Alcohol as an Anæsthetic.—The speaker related three cases in which complete anæsthesia was brought about during labor by large doses of alcohol. The uterine contractions were regular and easy; there was no trouble with the placenta, nor was there any post-partum hemorrhage. The pa-

tient was so completely under its influence as to experience no pain, and was entirely unaware of the passage of the child from the uterus. He thinks its action compares in these cases very favorably with that of chloroform.

Dr. T. A. Ashby has seen one major operation performed while the patient was under the influence of alcohol. The operation took an hour and a half. In this case, however, the whiskey (that was the form employed) was hardly pushed far enough, as the patient was somewhat hilarious during the operation. In this instance, however, he thinks the efficiency of the agent was greatly increased by fortitude and love for the whiskey on the part of the patient.

Dr. Van Bibber has employed alcohol in puerperal eclampsia for years with the happiest results. He keeps the patient perfectly relaxed for twenty-four hours. He has never had any reason to doubt its efficiency in these cases.—*Med. and Surgical Reporter*, Feb. 19, 1887.

Sinkler (W.), on Epilepsy due to Genital Irritation, and Cured by Circumcision.—The patient is colored, aged three years and five months. His parents are healthy, and have five other children; none of these have had fits, but one has had chorea. He was well until December, 1884, when he had two spasms. These were attributed to teething and taking cold. In January, 1885, he had another fit. The attack was marked, and lasted three or four minutes. Since that time he has averaged one fit a week. The attacks are severe, the convulsive movements being general, and afterward he is dull and sleepy. For several days past he has had an attack every day.

The child is well nourished, and shows no sign of rickets except that he is backward in teething. He is intelligent, and talks freely. The prepuce is elongated and inflamed at the edges, but can be retracted over the glans. Any touch, however, brings on an erection of the penis. The mother says that he handles the penis frequently, and seems to have some discomfort about it.

He was ordered potass. bromid. gr. ij. ter die. In one week returned and reported having had one attack. The bromide was increased gr. v. ter die.

August 2d. The boy has had thirty-five or forty attacks during the past weeks; some days twelve or fifteen fits. He has

become unable to speak, and seems to have lost his intelligence. The genitals are very irritable; a touch of the penis makes it rigid. Circumcision was advised, and the operation was performed by Dr. N. E. Goodman, August 9th. The bromide was continued in five-grain doses three times a day.

In the week after the operation he had two attacks. Since then there have been none. The bromide was taken for about three weeks.

I examined the child on December 27th, and he seemed well. He was bright and active, and talked freely.

Gowers speaks of a case of epilepsy in a boy of thirteen years who had twelve or fourteen attacks a day under various treatment. It was found that he was addicted to self-abuse, and a blister on the prepuce reduced the fits to from two to seven a day. Circumcision was then performed, and the attacks ceased at once and did not recur. This author advises circumcision in all cases of epilepsy when masturbation is suspected. —*Polyclinic*, Feb., 1887.

Kelly (J. E.) on Ergot in Cranial Injuries and Pulmonary Inflammation.—The patient suffered from a very severe cerebral concussion which was the result of a fall, and when I saw him he was rapidly passing into a condition of grave compression. The hypodermic injection of ergot distinctly retarded the progressive symptoms, and upon the treatment being continued the patient recovered with great rapidity. This satisfactory result encouraged me to test the remedy in several grave cases of head injuries, withholding the injection, when severe collapse was present, until reaction had set in, owing to the possibility of the ergot exercising any inhibitory influence upon the already enfeebled heart. This treatment gradually grew in favor, owing to the rapidity of recovery and the marked diminution of the appearance of severe symptoms in the great majority of head injuries which were subjected to it, until ultimately it became the routine of the hospital; the house-officers primarily administering one or more injections to the patients admitted to the institution with symptoms of intracranial injury. It is unnecessary to dwell upon the rationale of the procedure further than to mention that as a means of diminishing the reactionary circulation in concussion, and limiting extravasation in laceration, the utility of ergot, or some of its derivatives, is very obvious.

The pathological importance of the dilated arterioles, the capillary stasis, and the increased blood-pressure in active pulmonary hyperæmia and inflammation would naturally suggest the exhibition of a drug, the action of which is held by reliable authorities to induce the contrary conditions. When I gained my first experience of the efficacy of ergot in pulmonary inflammation, which was shortly after the cerebral case I have just described, I was not aware that Wycisk, in Germany, Yeamans, in America, and others had already administered it internally in pneumonia. It resulted from the necessity of affording relief to a lady who was compelled to continue her journey, after she had called at my office, suffering from acute pulmonary congestion, resulting from exposure and exhaustion. Her state was characteristic and most piteous, and the pathological condition suggested the remedy which promised the most rapid effect, namely, the hypodermic injection of ergot. The almost instantaneous relief which she experienced, and the fact that she required no subsequent treatment on her arrival at her distant home, impressed me profoundly.

Some three years ago I took charge of a patient in the second or third week of typhoid fever, who also had very extensive double basic pneumonia. At the time I regarded the case as almost hopeless, and yet, to add to my difficulties, a few days after, the anterior lobe of the right lung became involved, causing the patient intense agony and most distressing orthopnoea. Merely as a forlorn hope I injected ergot with the almost unexpected result of affording him a rapid though partial relief from the dyspnoea and a distinct mitigation of the acute pain. Again and again the inflammation attacked this lobe, and each time I treated him similarly with the same agreeable results. During this pitched battle between the ergot and the disease, which continued for two or three weeks, the posterior lobes progressed most favorably, and convalescence was established after a sickness of eleven weeks.—*Med. Register*, March 9, 1887.

Chisolm (J. J.) on Failure of Pupils to Dilate under use of Atropia.—The case was a man æt. sixty years, in whom there was refusal of the pupils to respond to the physiological action of atropia. In the left eye there was incipient cataract. He wished to dilate the pupil in order to

inspect the margins of the lens. Homatropin was employed with no result. He then instilled a four-grain solution of atropia and told the man to return next morning, which he did, but his pupils were still in their original condition. The four-grain solution was repeated with the same result. He then gave the patient a four-grain solution, and directed him to use it three or four times that day and return the next morning. On the following morning the drug had had no effect. Failing to get a response to atropia, duboisia, and finally hyoscyamia, was used, but failed to cause dilatation of the pupil. The other eye was then tried and the result was the same.—*Maryland Med. Jour.*, March 5, 1887.

Excision of Chancres.—Dr. Andronico claims to have entirely eradicated the syphilitic virus in four cases by excising the primary chancre. He believes that if the sore is situated in a locality such as the nymphæ or the prepuce, where excision is possible, and if the operation is performed within forty-eight hours, or at the very latest three days, from the first appearance of the chancre, success may be hoped for. The operation is, he says, contra-indicated if a longer time than this has elapsed or if the glands are enlarged.—*Lancet*, Feb. 19, 1887.

Jennings (C. E.) on the Preventive Treatment of Syphilis and of Hydrophobia.—Referring to the annotation which states that Dr. Andronico claims to have eradicated the syphilitic virus in four cases by excising the primary growths, permit me to point out the superiority of destroying chancres by means of the thermo-cautery as obviating the risk of reinfection of the system during the actual performance of the operation. I can now inform your readers with regard to the case of Mr. A. B. C. (published in the *Lancet* July 17, 1886), in which I destroyed a Hunterian chancre on November 11, 1885, with Pacquelin's cautery, and upon the suggestion of Sir William Jenner, carried out a course of mercurial treatment, that when I last saw the patient in September, 1886, there had up to that date been no secondary manifestations of syphilis.

On October 18, 1886, I saw a patient in consultation with Mr. Abbott of Braintree. A typical hard chancre existed on the left side of the corona penis, and its development had been noticed to have commenced since October 13th. This was destroyed with Pacquelin's cautery, the part having

been previously painted with a solution of cocaine to mitigate the pain, as in the case of Mr. A. B. C. A mercurial course was also suggested, and I have no doubt Mr. Abbott will be happy to report in due time the effect of the treatment. Here five days had elapsed since the first suspicion of infection before the destruction of the chancre, and such a delay is no bar to attempting the eradication of the virus—not even if the nearest lymphatic glands be enlarged, since this enlargement is probably at first of a simple and only later of a specific character. Owing to the very strong analogy which exists between the natural histories of syphilis and hydrophobia, *a fortiori* to the longer period of latency of the latter disease, there is ground for recommending that in all suspected cases of hydrophobia the earliest attempt to destroy the virus at the seat of inoculation should never be omitted. Add to these considerations the fact that only from five to fifty per cent. of those bitten by dogs and other animals, rabid or otherwise, really receive the virus of hydrophobia, and the argument in favor of treating these patients in the first instance by applying the thermo-cautery thoroughly to the cocainized part becomes insuperable.—*Lancet*, Feb. 26, 1887.

Leroy (Ch.) on the Action of Aconitine in the Treatment of Syphilitic Headache.—As a result of some experimentation, the author concludes that aconitia has no power to relieve the cephalalgia of syphilitics, and when the pain is due to a gross focal lesion the drug aggravates it. It is possible that some time this fact may be utilized in the differential diagnosis between functional and organic ailments.—*Annales de Dermat. et de Syph.*, Feb. 25, 1887.

Greene (W. T.) on the Treatment of Neuralgia by Hydrochlorate of Ammonia.—I am not aware that this drug has been generally used in the treatment of neuralgic affections, but in my own practice I have by repeated trials been led to look upon it as a specific, especially in those forms of the disease affecting the dental and facial nerves. I give it in from ten to twenty-grain doses every two hours, until the symptoms are relieved; but if after the patient has taken it four times the pain continues, it will be useless to persevere. In toothache proper it is often of great benefit; however, if there be inflam-

mation around the fangs of the tooth, hydrochlorate of ammonia will do no good. It may be administered in any convenient vehicle. I generally use either camphor or chloroform water; the latter is perhaps the better, as it somewhat disguises the excessive saltiness of the hydrochlorate, the greatest drawback to its administration.—

The Med. Press, Jan. 26, 1887.

Bidwell (W. D.) on the Long-Continued Effect of Cocaine.—A lady with conjunctivitis palpebrarum complained so much of the smarting after even a slight touch of copper sulphate, that I put in two drops of a two-per-cent. solution of cocaine hydrochlorate at 4.30 P.M. on Wednesday. This soon eased the smarting, and she went home. Sunday she called again, and stated that the effect of the drug, instead of passing off in from twelve to twenty-four hours, as I had noticed it to do in previous cases, had persisted till Saturday morning, the pupil being dilated and vision blurring, and all day Saturday there had been an uncomfortable sensation in the eye, though without the blurring of vision. The patient is of a markedly nervous disposition, which accounts, at least partially, for the prolonged action of the drug.—*Med. Register*, March 5, 1887.

Salicylic Eruption.—Burning sensations in the skin, oedema of the eyelids, and patches of bluish-red erythema were noticed by S. Rosenberg to follow the administration of four grammes of salicylate to a sempstress. A bullous eruption appeared on the site of the erythema as the result of continued use of the drug. Three days after the discontinuance of the drug the vesicles dried up. A fresh experimental observation was made, with a similar result. The urine gave a distinct ferric chloride reaction. The inunction of salicyl. ointment was followed by burning and red patches on the skin with blueness of face, and the urine showed the salicyl reaction.—*Lancet*, Feb. 25, 1887.

Jones (W. H.) on the Reckless Injection of Morphine Hypodermically.

—March 14, 1884. I was called to see a mother of a family of nine living children and two dead babies. She was propped up in bed, utterly unconscious; with harsh, stertorous breathing. Could not be aroused, nor could she swallow any water. A poor woman, of good, healthy constitution. The history of the case, from the family and attendants, was as follows: On the 10th of

March, 1884, although she was expecting to be confined soon, she walked across the fields, about $\frac{1}{4}$ mile, to spend the day with a neighbor, and walked home at evening. Next day, early, walked about $\frac{1}{4}$ mile, to another neighbor, and walked home before night. March 12, 1884, in the early morning, unmistakable labor pains came on. A doctor was called about 10 A.M., who, without making a vaginal examination, gave a hypodermic injection of morphine and went to visit another patient about two miles off and returned about 2.30 P.M. and gave her another hypodermic injection of morphine. Before night she gave birth to twins, one dead, the other died in a short time after: both well developed and born at full period. Next morning, the 13th, the doctor was called and he gave her another hypodermic injection of morphine, and on the morning of the 14th he was called again and gave the poor woman another hypodermic injection of morphine. The narcotic effect was marked from the first day, and shortly after the last dose stertorous breathing and utter unconsciousness came on and lasted until towards evening, when she died. It was a case of natural labor, no instruments employed in the delivery, and it would have been a blessed thing for that family if they had never seen the doctor.—*Cincin. Lancet-Clinic*, Feb. 12, 1887.

A Case of Submucous Laryngitis Treated by Hot Water.—Dr. A. H.

Buckmaster reports having succeeded in averting the necessity of tracheotomy by resorting to hot-water irrigation in the case of a girl, eighteen years of age, who had been for two days suffering with pain, hoarseness, and difficulty in deglutition. Urgent dyspnoea coming on during the night, the patient was placed on her side upon a rubber blanket, with the head lower than shoulders, and a stream of hot water, at about 120° F., was thrown against the oedematous tissues. At first attempts at swallowing were excited. Soon this difficulty subsided, and in the course of half an hour all distressing symptoms had disappeared. The author quotes at length from the experiments of Dr. Milne Murray in illustration of the effect of hot water upon the tissues, and refers to Dr. F. Addis Emmet as the one who first brought this therapeutic agent prominently to the attention of the medical world.—*N. Y. Med. Jour.*, Jan. 22, 1887.

MEDICINE.

Gerlier on an Epidemic of Paralytic Vertigo, a New Motor Neurosis.—

This vertigo is intermittent, and comes on in spells. A sudden pain starts in the nucha and radiates to the back; the sight becomes dimmed, the eyelids fall over the eyes, the strength fails, the legs flex, and the patient feels as if *very* drunk. The patient is generally at his occupation or in the street when stricken, and the attack is characterized by the three symptoms, muscular weakness, cervical pain, and ocular disturbance.

The paresis involves the extensors of the head, the levators of the eyelids, the extensors of the legs, and sometimes the depressors of the lower jaw and the extensors of the lower jaw. The pain in the nucha is never absent, and is a sort of sudden torticollis.

The ocular symptoms are limited to an amblyopia with a ptosis so complete that the patient must lift the lid to see where to walk.

The attack only lasts about five to ten minutes, is brought on by fatigue, and in the interval between attacks the health is perfect. Attacks never occur at night. The muscular groups involved are those which execute the rhythmical movements of certain employments. The disease is seen only in summer. In the first stage of the disease the patient has daily attacks coming on after midday, and after more or less muscular exertion. In the second stage many attacks occur daily, some in the morning, and all after or during some physical exertion.

Rest in bed stops the attacks entirely.

Towards the fall attacks become less numerous, and disappear altogether in November.

The disease is confined to farmers of Gex in the Franco-Swiss frontier.

Forty cases have so far been studied; all but one, so far, men.

As to the cause of this malady the author can say little. It originated in 1885, and followed exactly the progress of a milder.

As treatment, the author recommends more moderate work and protection of the neck from the sun. Cold baths have helped some cases. Quinine did no good; iodide of potash seemed to have a certain efficacy. —*Lyon Méd.*, Feb. 6, 1887.

Down (J. L.) on some of the Mental Affections of Childhood and Youth.—

The treatment of the various phases of feeble-mindedness resolves itself into medical and physical, and training, both moral and intellectual. The importance of commencing this betimes cannot be too much insisted on. Early training is of importance in preventing the growth of bad habits which become engrafted in the child. Constantly one meets with children who grow up a trouble to themselves and to those around them, from the injudicious treatment of some ignorant nurse who tyrannizes over the family by her supposed essential relation to the child. Much time is often required to undo the evil—even if it be capable of being counteracted. There are two great hindrances to the early and successful training of feeble-minded children arising from misconceptions on the part of many members of the medical profession. It is constantly said to the anxious parents of these children: "Do not be troubled, the child will grow out of it; wait till he reaches seven years," or, if the child has reached that age, then wait till he has reached fourteen. I know nothing of cataclysmal improvements, such as are here indicated. The opinion and advice have no basis in experience. The septennial periods here referred to are periods of anxiety and peril; they are not periods of sudden leaps from mental feebleness to mental vigor; they are, on the contrary, developmental crises full of danger, periods when wreck of what mental power exists is liable to take place.

The other great mistake in the medical advice which is often given is the instance to the mother that her child should not mix or be trained with children like himself, but with more intelligent children. Now, flattering as this may be to the parents, it is thoroughly baneful to the interest of the feeble-minded little one. The most successful training is effected with the child's equals; in this way a healthy emulation is established. Intelligent children will not take part in the amusements and games of feeble-minded ones. Moreover, there is no community of feeling or of interest. The outcome of an attempt to train the feeble-minded child with others more intelligent than himself is infallibly to make his life *solitary* and to accentuate the condition which it is of the greatest importance to correct. I have seen the relative of a nobleman, living in all the luxury of a well-

appointed country house, so put aside by her sisters, junior as well as senior, that she never ventured on a remark, and at length lost speech. I have seen the same girl transferred to a class of children like herself, pass from monosyllables to thoroughly conversational language amid the sympathy and companionship of her compeers. Mothers of feeble-minded children invariably think their children more intelligent than any others of a like category, and they only need the bias of medical opinion to put off proper and effective aid until it is too late. Being afraid of their association with others of the same class, the parents either send them to schools where their life is made wretched by teasing, and where they fall hopelessly behind, without the benefit of individual skill, or the hopefulness of collective emulation: or the boy is relegated to a country vicarage or Welsh farm, without any of the appliances or agencies which can develop his best possibilities. The first thing to be done is to rescue the feeble one from this *solitary* life, to give him the companionship of his peers, to place him in a condition where all the machinery shall move for his benefit, and where he shall be surrounded by influences of art and nature calculated to make his life joyous, to arouse his observation and quicken his power of thought. No one who can speak from experience in the matter would hesitate in saying that the companionship of their equals in intellectual power provides just the attrition which is desirable,—that the association with their superiors condemns them to a life of isolation which renders nugatory all efforts for their improvement. The fear that the association of a feeble-minded child with feeble-minded children will exercise an injurious effect upon the growth of intelligence is incorrect and not based upon experience.

Dr. Ireland has very well expressed that "imbecile children are no more injured by the presence of others of inferior intelligence than ordinary boys and girls are made childish by the appearance of a baby in the house,—that it is often, indeed, a great advantage for children to get rid of the uniform and hopeless inferiority in which they have hitherto lived, and to find that they have equals with whom they can interchange their simple ideas, and who give them a ready sympathy, and even to find that they have inferiors."

Those who have witnessed the transformation in children who have been removed from squalid cottages to a well-regulated institution, or have seen their joyous return from luxurious homes to their companions and their training, will be able to realize how truthful is a mother's account of her boy that: "When putting him to bed the last night he was smiles all over, saying, 'Going back to school tomorrow, mother,' and he packed his own bag before I could get to him in the morning, and could hardly finish breakfast, he was in such a hurry to be off, and went all smiles and delight."

It must always be kept in mind that the basis of all treatment should be *medical*. Medical, I mean, in an enlarged sense. Success can only be secured by maintaining the patient in the highest possible health. This is very well indicated by the intellectual torpor which follows or accompanies declension of health, and the lessened intellectual vigor which is met with in cold weather. I have referred to the hibernation which occurs among many feeble-minded children, and which has led me to notice that their intellectual vigor is *directly* as their external temperature. The pallor of the cineritious portions of their brains, which is so frequently met with, is suggestive of the importance of vigorously maintaining their nutritive life. A very liberal dietary is of great importance. It should contain a fair quantity of nitrogenous elements, and be rich also in phosphatic and oleaginous constituents. Green vegetables are very essential, as in their absence there is a great tendency to become scorbutic. Care should be taken that farinaceous food, as represented by the so-called corn flours, should give way to the more plastic elements of nutrition found in semolina, entire wheat flour, or macaroni. Not only must the diet be sufficient in amount and good in quality, it should be exhibited in a form suited to their power of mastication. Their bedrooms and sitting-rooms should be spacious and well ventilated, and especially well warmed.

The skin should be kept in healthy function by frequent sponge and other baths, not only for the sake of individual health, but for the health and comfort of their associates. The exhalation from the skin of feeble-minded children is something *sui generis*. It is of great importance that

their residence should be on gravel soil, and with well-made walks, that no opportunity may be lost for outdoor exercise. Warm clothing is essential, to prevent as much as possible the disastrous effects of climatic changes. I have before referred to the relative frequency of phthisis to the ordinary mortality.

Simple automatic movements, which I have referred to as being so common with the feeble-minded, should be replaced by others which are the product of will. We have to commence with very simple movements, gradually making them more complex. The want of co-ordination in the muscular system is very characteristic of the feeble-minded, and it is only by judicious physical training that the mutiny of the muscles can be overcome, and that purposeless acts can be converted into voluntary efforts suited for the wants of daily life. This training has to be carried out in great detail, so that every voluntary muscle and every system of muscles may be called eventually into action. In this way the various acts of prehension, locomotion, and mastication are taught, the tongue becomes a willing agent, the lips learn to retain the saliva which before gave our patient a repulsive look. I cannot enforce too strongly that little progress is made in speech until we first attain co-ordinated movements in their limbs. Finger lessons are to precede tongue lessons. I always remember the pinioned Frenchman who entreated that his arms might be freed because he wanted to speak. Unless we succeed in unpinioning the arms of our patients they do not speak. It is to be remembered too that we cannot bring into harmonious relation the muscles and the will without improving the physical quality of the brain and the other nervous centres. By these means, too, we shall have placed our patient into practical relation with the external world and initiated reasoning power.

The *moral* training is of great importance. He has to be taught, while his physical and mental powers are being developed by hygienic and physiological processes, to subordinate his will to that of another. He has to learn obedience; that right-doing brings pleasure, and that wrong-doing is followed by its deprivation. The affective faculties should be so cultivated that the deprivation of the love of the teacher should be the greatest punishment, and its

manifestation the highest reward. In this way indications of untruthfulness, selfishness, obstinacy, sensuality, theft, and unkindness to companions are checked. Corporeal punishment should be strictly forbidden. The tact of the teacher will be called into exercise in devising the suitable reward or punishment. I have seen a girl exhibiting violent obstinacy melted into contrition and obedience by the threat of the teacher that she would wipe from her face the kisses she had given her the previous day. In no case should the punishment interfere with the hygienic treatment. Nothing is worse than the deprivation of food for an offence. I have seen a case of violent and uncontrollable temper reduced to calm obedience by the administration of a basin of bread and milk. The moral delinquency was the result of mental excitement, the outcome of defective nutrition.

The *intellectual* training must be based on a cultivation of the senses. They should be taught the qualities of form and relation of objects by their sense of touch; to appreciate color, size, shape, and relation by sight; to understand the varieties of sound when addressed to the ear; the qualities of objects by their taste and smell.

It is desirable, however, to supplement the house and school by gardening and farming operations; by the lathe, the fret-work machine, the carpenter's bench, and, for the more advanced in education, the printer's shop. For girls, Kindergarten occupations and the various elegancies of needlework may be the outcome of persevering endeavors, while music and dancing may for all alternate with dramatic entertainments, which are most useful in appealing both to the eye and the ear. Care should be taken that the physical should interchange with the intellectual training. It is of the greatest importance that the teacher should keep clearly in view that his primary object is to make the pupil self-helpful, and, as far as possible, a useful member of the community; in this way more is done than by any other means. Mere *memoriter* knowledge is of little value; every thing which makes him practically useful, makes him proportionately happy.—*Med. Press*, Feb. 9, 1887.

Free (J. E.) on the Treatment of Chorea.—When I was a boy thirteen years old I had an attack of chorea, which commenced in March and lasted until

September. During the preceding fall I had been troubled with rheumatism, and from the date of a polyarthrititis, accompanied with heart complication, I was more or less inclined to disorder of the nervous system. But it was the beginning of spring before I left school to undergo special treatment.

There were at the time two cases of chorea in the neighborhood, and it was the opinion of some that I had acquired the disease by either contagion or imitation. The suspicion was unfounded, because it is a fact demonstrated by experience that association (which did not take place) cannot produce chorea, and as a special germ has not been discovered in the blood with the microscope, there is no proof of contagion. The cause in the other cases was undoubtedly sexual indulgence; the female, who was one of the subjects, gave birth to an illegitimate child at the age of sixteen about two years afterwards.

Several plans of treatment were tried unsuccessfully, and as a last resort, I was placed on a farm and allowed to run wild. My experience there taught me something about chorea which I have ever since regarded as indispensable in its treatment.

The first thing that struck me as being necessary in my case was freedom from observation. When satisfied that nobody was watching me I had much greater control over the muscles of voluntary motion than at other times. I could take a glass of water at a certain spring without much inconvenience, but at the table I was liable to make the most awkward and fantastic motions. The reason for the increased difficulty when in the presence of others was my morbid sensibility, and the tension of an effort to appear unconscious of observation brought on a second stage of relaxation and motor excitement. Sustained mental activity was impossible; some of my attempts at writing are still preserved. The letters of an occasional word are fairly well formed, although the greater portion appear to have been constructed by a hand which did not know in what direction it would move next. Sitting still was absolute torture in the presence of others; if alone, I could sit down in a chair and be comparatively quiet; but the moment a footstep was heard, I was completely unstrung, and would be compelled to vibrate like a toy suspended by a piece of rubber. The will had lost the power to exact obedience from

the muscular system; trying to do any thing that required complex motion, or the effort to sit still, would cause chilly sensations to fly over me, my skin would itch, and there would be creeping feelings and subsultus and tic. And like a chill, these sensations would be followed by a stage of excitement; my pulse would run up high and become irregular; my heart would not pulsate synchronously with the radial artery, and respiration would not be rhythmical, and my legs and arms and head would fly off at a tangent.

Another thing which I found to be useful was a support for the back. The recumbent position abolished the muscular tremor to a marked degree, and after a night's rest there was absence of symptoms until attempts at coördination brought them back.

Sometimes when worn out by a hard day's work, if compelled to watch by the side of a patient, I feel the same restlessness. Every physician knows that nameless longing to stretch and yawn, accompanied with tingling and pricking sensations, which overtake the weary watches during his vigils; they are the same the choreic patient experiences. Another peculiar sensation in my case was connected with the larger blood-vessels. I can compare it to nothing better than the emptying of a bottle of water. The way the water escapes reminds me of the sudden emptying of blood out of an artery; and although not distinctly audible, I imagined that the sounds of the two actions resembled each other.

From what I experienced, I think the circulatory apparatus is the seat of the trouble. I had an attack of rheumatism previously, and there was implication of the cardiac structures, and that fact may be sufficient to account for the irritation of nerve-centres by molecular particles of fibrin set free from an inflamed endocardium. Hughlings Jackson claims that in chorea there is a minute embolism of vessels in the convolutions near the corpus striatum; that portion of the striatum, as the anatomist knows, is supplied with blood by the branches of the middle cerebral artery, and interference with its nutrition would account in some measure at least for the muscular instability.

There are numerous causes for chorea; thus tenia, a foetus, masturbation, etc., may serve as samples. By some writers fright

has been placed at the head of the list, but how it can produce the effects which morbid anatomy proves to exist, is an unsettled question. Masturbation is a cause the frequency of which is hard to estimate, because the secret is almost sure to be concealed with great cunning as long as possible; however, genital congestion is a frequent post-mortem appearance. The situation in a case of chorea seems to be this: there has been an exhausting drain upon the nervous system, the centres which control the circulatory function are not supplied with their normal food, and consequently deterioration of tissue results.

Thorough oxygenation of the blood always made me bright and hopeful, and I soon learned that the close atmosphere of a house aggravated the disease, while outdoor exercise, and especially expansion of the chest, produced a tonic effect. The cause of the morbid manifestation settles the question of the applicability of arsenic. A friend of mine, who practises in a malarious district, extols the following:

℞ Strychnia sulph.
 Acid arsenious ʒss gr. j.
 Hydrarg. bichlor. gr. ij.
 Quinia sulph. 3j.
 Gentian q. s. ft. pil. No. xxx.

One pill to be taken three times a day.

Cases of chorea that do not show a tendency to recovery when their surroundings are favorable should if possible be placed in a secluded spot where freedom from observation and plenty of fresh air can be obtained. Those who have not realized the morbid sensibility of choreic patients cannot appreciate the necessity for withdrawing them from the contact of society, and also the foolishness and futility of attempts to overcome that feeling of timidity by such devices as are common in dealing with hysteria.

Every morning the patient should have a nourishing breakfast, and afterwards a bath. "Suppose the patient will not eat?" you say. Yes, but he will eat when once he begins to feel properly oxygenated blood coursing through his body, unless his disability is so great as to interfere with mastication and deglutition. If he refuses food, there is probably some disorder of function that can be reached by means of our art. The problem is to obtain the best substitute possible for nature while we encourage and educate the sluggish faculties to resume their sway.

Bathing and rubbing are important. Chorea is a disease that makes the surface of the body uncomfortable. Subsultus is common, and a bath in water of a comfortable temperature, in a comfortable apartment, to be followed by rubbing with dry towels, brings the blood to the surface, and causes a grateful sensation of ease instead of the itching, uneasy feeling.

After the bath some method of gentle exercise should be practised. What is indicated is something to cause a shaking-up of the entire system. Nothing violent should be tried. Motion, such as is obtained by moving down stairs, will suit patients who are large and intelligent enough to practise it. A regular lesssoff in calisthenics is not desirable; neither are dumbbells and Indian-clubs, because to obtain the supposed benefit a certain power of concentration of the mental faculty is demanded when perfect abandon is the desideratum. Executing a dance is good—not the intricate parlor figures, but only the jumping, up and down motion—by which, especially, the muscles of the extremities are thoroughly used, and the entire body shaken. The greatest caution is necessary in commencing these lessons, because to one unaccustomed to them only a few minutes' exercise is sufficient to cause stiffness and pain in the over-worked muscles, along with headache, nausea, etc., the following day.

I am in the habit of insisting upon a gradual increase in the amount of exercise. Beginning with a short lesson, say twenty to fifty jumps, the number is increased until two or three hundred is reached. This need not take more than ten minutes daily, and when once habituated to it, as the patient is likely to be in a short time, no interference with digestion need be feared. Instead of becoming irksome, these daily lessons are enjoyed, and I have several times had to restrict the number and amount of each.—*Med. and Surg. Reporter*, Jan. 22, 1887.

On the Treatment of Chorea.—The special and varying circumstances of each case require to be dealt with by variations in the treatment, or by the employment of more than one therapeutical measure; so that the rigid requirements of a strictly scientific test of the efficacy of treatment

¹ A part of the report of the Collective Investigation Committee of the British Medical Association.

can rarely be fulfilled. Moreover, an attack of chorea being of indefinite duration, it is a disease peculiarly unsuited for testing the comparative efficacy of different methods of treatment. Thus, in the great majority of cases under consideration, several methods of treatment were employed, sometimes simultaneously, sometimes in succession, and the observer is only able to state his opinion that, at a certain stage of the affection, some remedy appeared to exercise a beneficial influence.

In the first place, it may be stated that comparatively few patients were treated without drugs. In a certain number of cases, however, feeding appears to have been chiefly trusted to, presumably in conjunction with rest, etc.

The best cases illustrating the effect of feeding alone are a series of cases reported by Mr. Holland Wright. These briefly are as follows: No. 373, moderately severe, duration two months; No. 375, severe, duration three and three-quarter months; No. 376, moderately severe, duration three months; No. 377, severe, duration six weeks. None of these cases were attended by rheumatism or any other complication in the attack. The only treatment recorded is "Full diet." The average duration of the attack in the series of four is ten weeks, which is about the average duration of the whole series of cases however treated. The same may be affirmed of the other cases treated without drugs.

Secondly, it may be safely affirmed that there is no drug that exercises a specific influence over the course of the disease; the same drug which appears so successful in some cases, failing entirely in others. Two drugs appear to have been most generally used—namely, arsenic and iron—drugs which are generally recommended in the treatment of this disease, and which the attendant circumstances of the disease, especially the anæmia, naturally suggest.

Arsenic appears, in some cases, to have been strikingly useful, but, on the other hand, in a great many cases, the disease does not appear to have been markedly influenced by it. The cases in which arsenic is recorded to have done good were eleven in number—Nos. 34, 125, 126, 138, 169, 200, 203, 209, 214, 297, 330.

Iron, though so frequently employed, was in five cases the only drug given.

Salicin and Salicyl Compounds.—Considerable interest attaches to the group of

cases of chorea treated by salicin and salicyl compounds, whatever view is taken as to the relationship of chorea and rheumatism. Attention is directed to the following cases.

No. 38, female, aged fourteen; first attack; hemichorea. Rheumatic fever two years before; subject to slight rheumatic pains at times. Mother has subacute rheumatism. No rheumatism during the attack; heart normal. Marked improvement under salicin in three-grain doses when sulphate of zinc, belladonna, and bromide of ammonium had failed. (O. E. B. Marsh.)

No. 103, female, aged thirteen; first attack. Scarlet fever three months, followed by vague pains until attack. Attack attributed to scarlet-fever and rheumatism; heart normal; no rheumatism during attack; hemichorea affecting the side which had just suffered most from rheumatism. No improvement under iron and quinine; rapid improvement under treatment by salicylate of soda. (W. Taylor Colby.)

No. 104, female, aged five and a half; first attack. Scarlet-fever five months before, followed by vague pains. Attack attributed to scarlet-fever and rheumatism; heart normal; no rheumatism during attack. A severe febrile case, lasting eight weeks; deglutition and speech greatly interfered with. No improvement with iron and quinine; rapid improvement with salicylate of soda. (*Idem.*)

No. 125, male, aged sixteen; first attack. Vague pains three months; subacute rheumatism in a few joints during and after attack; heart normal. "History of overwork during subacute rheumatism." No relief under treatment by bromide of iron; slight relief under treatment by salicylate of soda; marked and immediate relief under treatment by arsenic. (William Armstrong.)

No. 131, female, aged eight; first attack, severe, febrile, and lasting about three weeks. No antecedent rheumatism, but acute in a few joints during and after attack; heart normal. Rapid recovery in three weeks under treatment by salicylate of soda (and Dover's powder, two nights). (J. F. Joseph.)

No. 171, male, aged thirteen; first attack. Vague pains a few days before the chorea; no rheumatism during attack; heart normal. A very severe febrile attack, could not articulate for a considerable time. Arsenic was given freely for some time;

did no good. Salicylate of soda then given with much benefit; drug stopped, chorea relapsed; drug resumed, not so much benefit as before. Arsenic completed the case. (James MacNee.)

No 245, female, aged nine; second attack; the first a slight one. A few years previously, rheumatism, with some joint affection, and temperature of 103° Fahr.; preceding month, subacute rheumatism in a few small joints during attack. Heart normal before attack; during attack, loud systolic mitral murmur; five weeks after, apex normal, murmur faint, not constant. Attack moderately severe, lasting nine weeks; temperature occasionally 103° Fahr., probably due to rheumatism; joints painful, no effusion. Yielded to salicylate acid, followed by digitalis and iron. (J. P. Wills.)

No. 362, female, aged thirteen; second attack; the first thirteen months before. Rheumatism with distinct joint affections six months; rheumatism with fever three months; acute rheumatism in many joints during attack. Family rheumatic and subject to quinsy. Acute rheumatism after first attack. Heart normal. Attack moderately severe, non-febrile, lasting three weeks. No relief from bromide of potassium; relief in twenty-four hours from salicylate of soda (one drachm daily). (Thomas Fiddes.)

Amongst the other remedies stated to have been of benefit are the following:—

Sulphate of zinc, five cases.

Valerianate of zinc, one case.

Oxide of zinc and belladonna, two cases.

Iron and arsenic, five cases.

Arsenic and bromide of potassium, one case.

Chloral, four cases.

Bromide, iron, and nux vomica. Iron and strychnine. Iron. Bromide of potassium. Strychnine. Conium. Physostigma. Nephenthe. Gelsemium. Santonin. Gymnastics. Galvanism. Massage. Blisters to spine. Opening abscesses. Destruction of worms. Food. Sponging. Change of air.—*Brit. Med. Jour.*, Feb. 26, 1887.

Squires (G. W.) on **Convulsions from Impacted Fæces in a Young Child**.—On the 15th I was hastily summoned to see a little girl eleven months old who, the messenger said, was dying in a fit. On my arrival I found the child just recovered from a convulsion, but there was twitching of the muscles and every indica-

tion of more convulsions. The thumbs were fixed in the palms, the eyes were wild and squinting. Upon examination I found the abdomen greatly distended, with hard, knotty-looking lumps, which were readily recognized as being in the bowels. The mother made the remark that the child had been "terribly constipated"; that she had given her as much as three tea-spoonfuls of castor-oil without a movement of the bowels; that she had been in the habit of feeding her on potatoes, cabbage, bread, and in fact every thing she ate herself. Every few minutes the child would cry out, and bend almost double. I at once ordered injection of warm water and castile soap, and in ten minutes the bowels moved, bringing away a great quantity of hardened scybala the size of hickory nuts; the child immediately felt relieved, and soon went to sleep. At the end of an hour she started up with another violent griping pain. Another injection was immediately given, bringing away more fæces covered with mucus; a few grains of comp. licorice powder was given, and the injections were repeated seven times, each time bringing away less hardened dejections, until the last was of quite natural consistency. The fever-thirst and convulsive symptoms disappeared as if by magic, the child asked for playthings, and was more bright and cheerful than it had been for weeks. The mother told me that the night before the convulsion the child had a severe attack of croup, which was undoubtedly of reflex origin.—*N. Y. Med. Record*, Feb. 26, 1887.

Tchudnovsky on Epileptoid Fits Caused by Tænia Solium.—Dr. J. B. Tchudnovsky, of Viatka, reports ("Proceedings of the Viatka Medical Society," Nos. 7-12, 1886, p. 22) the case of an anæmic, delicate woman, aged thirty-four, who for the last eight years was subject to fits, which at first came only two or three times a year and lasted usually a quarter of an hour, but later on commenced to occur once monthly and to last sometimes an hour or so. The fits were ushered in by loss of consciousness (without uttering a cry), and consisted in clonic and tonic convulsions of all muscular groups in the body, those of the facial and cervical muscles being invariably the last to disappear. According to the patient's statement, she suffered from her childhood from tapeworms, which began especially to trouble her during the last three years, the prognot-

tides incessantly escaping from her anus even when she sat quite quietly. Her sleep was interrupted, stools coming only once every five or six days (and that only after laxatives). The administration of extract of male fern, kamala, and kousso expelled at various occasions only headless tapes, about twenty-five to thirty-five feet in length. The fits continued; they even increased in frequency when the author tried a four-months' course of bromide of potassium with Fowler's solution and morphia. The failure of nerverine induced Dr. Tchudnovsky to again take resort to anthelmintics. This time about one hundred and sixteen feet of the worms were discharged, and a head of a *tænia solium* was at last found. The convulsive fits disappeared and did not recur. The general state of the patient rapidly and steadily improved. Judging from such an enormous length of the tapes, the patient undoubtedly was a host of several parasites. The future will show where were or are the other heads.—*London Med. Record*, Dec. 15, 1886.

Mann (E. C.) on the Psychological Aspect of Three Cases of Infanticide Considered in their Relation to Forensic Medicine.—The person whose mental unsoundness is suspected should

1. Be examined as to his past history and that of his family. Insanity is generally hereditary, although not necessarily so.

2. The examination of the patient, if not showing hereditary insanity, may show other neuroses or nervous diseases, such as epilepsy, chorea, paralysis, hysteria, vertigo, etc.; either in the suspected insane man or woman, or their family.

3. There may have been a change of habits or disposition, the result of injuries to the head, sunstroke, fevers, or syphilis. The existence of disease of the lungs, heart, or kidneys is also important.

4. Examine as to the mode or manner of the crime. Many sudden, motiveless, peculiarly atrocious murders are the work of epileptics. Did the criminal attempt to conceal the crime or himself?—*Alienist and Neurologist*, Jan., 1887.

Robinson (B.) on Heart-Strain and Weak Heart.—From the author's study it may be reasonably inferred:

1. There is a class of cardiac disease to which the names of "heart-strain," "heart over-strain," or "weak heart" may be properly given at the present time, and un-

til this class has been more carefully subdivided.

2. In this class are now included cases in which there are no marked physical changes, and in which the symptoms alone indicate cardiac weakness.

3. In many cases the physical cardiac changes are more or less marked, and usually show some dilatation, joined or not with slight or moderate thickening of the ventricular walls, and accompanied or not with mitral or aortic incompetency.

4. There are cases in which the heart is obviously somewhat enlarged, although there never have been any morbid symptoms which showed cardiac weakness.

5. The causes of these affections are numerous; among them, however, prolonged or excessive physical exertion is often, although not always, prominent.

6. In some cases the disorder seems to be one more of neurosal than muscular deficiency, and may affect the function of the pneumogastric nerves, the sympathetic, or the intracardiac ganglia.

7. In several instances the causes of cardiac disorder are very obscure or wholly unknown; and in such instances we must admit the existence of a *weak heart* primarily, that is sometimes first recognized suddenly and without premonitory indications which shall enable us to foretell such condition of cardiac debility.

8. Absolute or relative repose, appropriate diet, change of scene, chalybeates, cardiac tonics, counter-irritation, etc., employed judiciously, will do much in most cases to restore real or apparent cardiac vigor for a shorter or longer period.—*N. Y. Med. Record*, Feb. 26, 1887.

Clark (A.) on Cases of Valvular Disease of the Heart, Known to have Existed for over Five Years without Causing Serious Symptoms.—There are many persons with long-standing valvular disease of the heart, engaged in the active business of life, who, without any symptom of heart disorder, have enjoyed good health and have reached an advanced age.

Mitral regurgitant murmurs, so often encountered in chorea, for the most part disappear within eight or nine years of the attack.

Valvular inflammations, and their effects arising in the course of rheumatic fever, do sometimes disappear, and leave behind no clinical evidence of their former exist-

ence ; and that this occurring for the most part in the young, also occurs sometimes in the middle-aged.

The signs of valvular defects arising out of the degenerative changes of middle life do also, on rare occasions, disappear, and that, when circulatory and respiratory disturbances accompany their commencement, they sometimes subside, and permit of comparatively complete readjustment.

As there must be in the histories, habits, occupations, and surroundings of patients with valvular disease conditions which, in one case, bring about secondary disorders, and, in another case, exempt it from them, it is desirable that the respective *differentia* should be discovered, and made capable of application to practice.

Any systematic and critical study of this subject likely to lead to practical issues could be undertaken only by the Collective Investigation Committee, and not by it, unless actively assisted by experienced general practitioners who possess, in a special manner, the knowledge necessary to the end in view.

A joint inquiry of the kind proposed, conducted with due patience, discrimination, and accuracy would greatly extend our knowledge of the natural history of diseases of the heart, and largely increase our means of assisting those who suffer from them.—*Brit. Med. Jour.*, Feb. 19, 1887.

Hayem (G.) and Barrier (G.) on the Effect of Transfusion of Blood into the Heads of Decapitated Animals.—The result of their experiments is as follows :

The extinction of sensation and will is a very speedy if not immediate sequence of decapitation. Evident signs of life appear in a decapitated head when immediate injection of arterial blood is resorted to. Even several minutes after decapitation, if transfusion be resorted to, automatic movements and many and extensive reflex movements appear, but there is no return of sensibility nor will. The experimenters concluded that the pons and medulla alone are re-excited to a functional activity.—*La France Méd.*, Feb. 12, 1887.

Hunter (W.) on the Duration of Life of Red Blood Corpuscles After Transfusion, in its Bearing on the Value of Transfusion in Man.—Experiments furnish us with sufficient data to enable us to arrive at a tolerably accurate

estimate of the life-duration of red blood corpuscles after transfusion. We have seen how, in the dog, in conditions of health, an excess of corpuscles, amounting to as much as twenty to thirty per cent. is got rid of in the course of a few days, the rate of destruction being as great as five or six per cent., or even more daily ; and we have further seen reason to believe that man will approach very closely to the dog in respect of the activity of his various bodily functions. In man, however, we can rarely transfuse a quantity of blood equivalent to more than five or six per cent., a quantity probably utterly insufficient to influence in any material way the general mass of the blood, since its destruction under ordinary circumstances may be expected to occur within a day or two at most. But if it be remembered that in cases of pernicious anæmia we are transfusing these corpuscles into an organism whose own blood corpuscles are being destroyed with undue rapidity, it may be fairly regarded as doubtful whether the introduction of corpuscles under such circumstances can be of the slightest value at all—namely, if the value of the operation is to depend on their continuance in life for some time afterwards. It may, however, be urged that, in other conditions of anæmia—namely, those depending on diminished production,—the same argument cannot apply against the efficacy of transfusion, since, under such circumstances, as has already been seen, the process of blood-destruction is probably also diminished. This is probably the case, but in such conditions there is little or no occasion for resorting to such an extreme measure. We have seen that the absence of corpuscles does not in itself constitute any immediate danger ; we have ample evidence of this in many cases of anæmia in the human subject, in which the corpuscles are reduced to 700,000 or 800,000 per cubic millimetre, without occasioning the slightest disturbance to the patient, excepting, of course, a sense of weakness with dyspnoea on the slightest exertion, but no disturbance of immediate danger to life. Hence the resort to transfusion under such circumstances is not in many instances called for ; we are able in other and simpler ways to effect our purpose of restoring the blood to its normal condition.

The increased supply of oxygen conveyed to the tissues by the new blood corpuscles may be considerable, and may be

capable in some way of modifying the diseased processes on which the anæmia depends. But, since this supply is dependent on the corpuscles, and its continuance is co-terminous with their life-duration, it may be considered doubtful whether this consideration alone is of such importance as to justify the performance of transfusion of blood in such cases, especially as we have seen reason to believe that the deficiency in oxygen supplied to the tissues, as in cases of chlorosis, is not accompanied in itself with any very serious results.

Lastly, the only other way in which transfusion of blood corpuscles can act efficaciously in conditions of anæmia, is by the introduction of a certain quantity of hæmoglobin into the system, which may serve as a stimulus to the blood-forming glands, and thus stimulate them to an increased production of blood corpuscles.

Of all the possible ways in which transfusion of blood may act, I am inclined to regard this as the one most likely to explain the beneficial effects which sometimes follow that operation. This conclusion is based on the results of my observations on the destruction of blood within the various organs of the body, especially the liver, the spleen, and the bone-marrow, and the effect of an accumulation of blood pigment within these organs on the nutrition of the animal.—*Brit. Med. Jour.*, Jan. 29, 1887.

Weber (A.) on the Treatment of "Cheyne - Stokes" Respiration.—Leube has electrized the phrenic, Rosenbach the pneumogastric, and Bernheim the cutaneous, nerves of the face and neck, with little, if any, result. The same is true of inhalations of oxygen (Sacchi) and nitrite of amyl (Filehne). According to the writer, the hydrochlorate of morphine alone successfully combats the symptoms due, almost always, according to Huchard, to a cerebral anæmia.—*L'Union Méd.*, Feb. 19, 1887.

Fraipont (F.) on the Treatment of Erysipelas.—The method employed by the author, and which he credits to Von Winniwarter, is as follows: He places the erysipelatous limb in a tepid bath of a 3 % solution of corrosive sublimate leaving it there about ten minutes. The wound should be well protected from the solution. If the part cannot be immersed, the reddened surface should be washed with the same solution about the same length of

time, not sparing the wound. The part is then painted with tar all over the erysipelatous region, and two or three fingers' breadths beyond, and covered with iodoform gauze slightly moistened with the sublimate solution, and around this other moist dressings and a bandage. The next day considerable desquamation will have taken place, and a much weaker, perhaps $\frac{1}{2}$ %, solution will suffice. Such treatment requires great care, but according to the author is successful.—*Ann. de la Soc. Méd.-Chir. de Liège*, Jan., 1887.

Von Nussbaum on Erysipelas.—Recent times have brought about great changes in treatment. In former ages this infective disease was completely inexplicable to the physician, in consequence of which all sorts of nonsense were perpetrated. Patients would have the disease prayed—charmed away. Then came the time in which bad fluids in the stomach and intestines were looked upon as the cause, and in which unfortunately emetics and purgatives were had recourse to. Only during the last ten years was the right way hit upon, and the surgeon began to destroy or disinfect all foci from which infection was to be feared. Badly smelling teeth and sequestra were removed, the shortest way was opened for the free exit of purulent collections, care was taken that the exit passages of diseased secreting organs were not blocked up, proper attention was paid to fresh air, comfortable rest in bed, the attendant acted withal upon all se- and ex-cretory organs, cooled the hotly glowing, reddened erysipelatous surfaces with cold lead lotion, and sought to set up a barrier against the farther advance of the erysipelas by applications of tr. iodi., turpentine, solutions of arg. nit., or by incision made with the knife, or with the cautery applied to the periphery, and combatted the destructive high temperature by antipyretics, quinine, and later salicylate of soda, antipyrine, thallin, salol, etc.

The endeavors to set a barrier to the advance of the disease have not so far been at all successful, and antipyretics have not effected much. But as it became confirmed through Hueter's incessant endeavors that in every part of the skin when erysipelas was present, cocci were also to be found, and that where there were no cocci, there was also no erysipelas, then it was that the antiseptic method began its successful career. Tar, oil of eucalyptus, turpentine,

carbolic acid, boracic ointment were painted upon the erysipelas, foul smelling and diphtheritic openings were swabbed out with strong carbolic acid solutions, but with all these endeavors no result followed in controlling the advance of wandering erysipelas even if the degree of infection was somewhat reduced by the means just mentioned. Only when Hueter undermined the whole superficial area of the erysipelas with a two-per-cent. solution of carbolic acid in water was the disease conquered and advance completely put a stop to. I confirmed the efficacy of this treatment with great joy, for it is a triumph of antisepticism. When following Hueter's example I injected morning and evening a two-per-cent. solution of carbolic acid completely round the margin of the erysipelas, and about a syringeful (a cubic centimetre) to each four or five square centimetres, the erysipelas in every case was arrested.

I had in vain tried all the above-mentioned plans to prevent the spread of the erysipelas. Hueter's method alone had brilliant success, but the procedure was painful, it could almost be called cruel, and consequently found little employment. The method which Kraske recently published, viz., that of scarifying the erysipelas and overlaying with carbolized compresses, I have never tried, as I consider it more painful than Hueter's, whilst it does not effect more.

If in accordance with Klebs' proposal fifteen to twenty grm. of benzoate of soda are daily given in a mucilaginous solution or in seltzer water, an arrest and fall of the erysipelas are often observed.

In the last few weeks, however, I have had the great joy of successfully arresting and quickly healing the erysipelas in a perfectly painless and easy manner, and that is the reason of my address to-day. I would incite all surgeons to make the experiment that has with me succeeded several times, which may be called a great advance, for erysipelas has hitherto been a true *crux medicorum*.

From all that Unna of Hamburg has published concerning ichthyol, from all I have myself observed, I must consider this distinguished remedy to be a so-called reducing agent.

Everywhere it reduces the condition of irritation, the superabundant nourishment. Several times I made the following experi-

ment: When erysipelas had attacked a wound, after proper disinfection of the wound, and covering it with a small, fitting, iodoform gauze compress, I painted the whole erysipelas, still spreading in all directions, with ichthyol ointment made of equal parts of ichthyol and vaseline. I then covered the part painted over with ten per cent. salicylic lint, and fixed it on with a hydrophilous gauze bandage. On the following day I was infinitely joyfully surprised: the erysipelas, the margin of which I had plainly marked out, had not only got no farther, but the surface itself had undergone a favorable change. The red, swollen, shining, succulent skin had become sunken, shrivelled into yellowish-brown creases, the pain also, which was felt yesterday on contact, had given place to a velvety (*pelzig*) feeling—in a word, all symptoms of active irritation were, as it were, charmed away and returned no more, although I only used the dressing for three consecutive days. A longer continuance would have been disagreeable to the patient, as the ichthyol on the third day had somewhat affected the skin. I have already had five consecutive cases of erysipelas of the extremities that I have treated with equally surprising results. In erysipelas of the face, perhaps ichthyol collodion suits better, and on the hairy scalp ichthyol soap. Concerning this I have had no experience, for erysipelas has, since we have adhered to strict antiseptics, thank God, become a rare disease. If such a case were not frequently introduced from the town into the hospital, we should for a long time have had no opportunity for these new experiments.

As regards the healing power of ichthyol, I must remark that ichthyol is no antiseptic, and decidedly cannot destroy the erysipelas cocci. When it is thus so successful in erysipelas, it seems to me likely that the reducing action of the ichthyol so starves the nutrient soil of the cocci that it is no longer suitable for their multiplication. Many surgeons have thought they have observed an antiseptic action from large doses of ichthyol; I myself consider it to be so small that I do not hold it to be strong enough to destroy the cocci of the erysipelas, for they have, as is known, a tolerable tenacity.—*Med. Press*, Jan. 26, 1887.

Drowsiness Accompanying Dyspepsia.—Drowsiness accompanying diges-

tive troubles is very common. The patient is anæmic and irritable, troubled with palpitation, and sensation of fulness after meals, caused by flatus. Bowels may be constipated or not. Used to a sedentary life. The principal points, however, to be looked to, are the teeth and urine; the former are bad, and the latter scarcely acid, or else alkaline, and often phosphatic. Alkalinity or deficient acidity is probably present in the stomach, and germs from the teeth swallowed in the saliva. In the stomach, as a rule, the trouble commences; hence the distension and, from pneumogastric irritation, the palpitation. Pepsine can only act in an acid medium, and so the food undergoes some abnormal decomposition, with the production of gas instead of normal digestion. It is not difficult to imagine that the products of such changes, taken up and passing through the liver into the general circulation, would produce toxic symptoms. The brain, already badly nourished and anæmic, cannot work with blood deficient in oxygen-carrying corpuscles and loaded with morbid products as well. It therefore "sleeps," disturbed, however, by fitful dreams as more or less irritating matter is supplied to it.

What should be the treatment of such a condition? Simply supply what is deficient. If there be constipation, a mild aperient—say, ext. casc. sag., gr. iii., o. m. ante cib. Attend to the teeth. For the alkalinity and palpitation the following: *℞. Acidi hydroch. dil., m. xv.; tr. nucis vom., m. x.; tr. calumbæ, m. xv.; aquam ad 3 i.; ter die post cibos, with or without succus taraxaci, 3 i., or vin. pepsin., 3 i., as required.* Limit smoking. Stop all tea, coffee, cocoa, and hot fluids. Let the patient drink cold water for breakfast, light ale, claret, or water at dinner—say, at 2.30—and a light supper at 8 P.M., with the same drink, and no fluid between meals. Nearly finish every meal before drinking. Advise friction with a towel over the abdomen, sufficient out-door exercise, and early bed.—Letter to *London Lancet*, Feb. 19, 1887.

Thirst in Infants.—Thirst is a sensation which is relieved by the introduction of some liquid into the alimentary canal, consequently, a very general impression prevails that milk, being a liquid aliment, is at the same time a drink which will appease thirst. This belief, however, is erroneous. Milk, the type of a food, calms

hunger but often only aggravates thirst, especially when digestion has begun. It is for this reason that, much to the astonishment of mothers, infants often cry for more soon after a copious meal of milk. To put the child again to the breast is only to add fuel to fire and to pave the way for a serious attack of indigestion. The explanation is not difficult. The first thing that happens when milk is introduced into the stomach is the precipitation of the casein in the form of curds, the digestion of which is apt to overtax the supply of gastric mucus, more especially as the supply is by no means abundant in infants. The curds thus incompletely macerated tend to form lumps, sometimes of great size, which disorganize and fatigue the functions of the stomach. All circumstances which tend to lessen the proportion of liquids to solids in the stomach, give rise to the sensation of thirst, and if the mother will only supply, at the proper moment, a genuine liquid, such as water, digestion recommences energetically, and goes its course. No risk can attend giving infants now and again a teaspoonful or two of water, and the best way is to give it tepid and slightly sweetened.—*Med. Press*, Jan 26, 1887.

Amidon (R. W.) on Typhoid Fever Simulating Cerebro-Spinal Meningitis.—The specimens were from the body of a woman, aged thirty, who was a patient of Dr. A. F. Currier. About November 19th she began to suffer from pain in temples and occiput, worse in the latter region, and much pain and stiffness in the back of the neck. She had some chills, and thought she had caught a severe cold. She was first seen by Dr. Currier November 26th, when all these symptoms were aggravated. Her temperature was 103.8° F., pulse 100, and she had no abdominal symptoms whatever. The nervous symptoms continued, and the temperature ran a peculiar course, there being a remission on the morning of December 6th. Some anti-fibrine was then being given, but not enough to explain the low temperature. Dr. Amidon saw the patient in consultation once only, December 8th, on the eighteenth day of the disease. Then, at 8 P.M., the temperature was 103.6° F., pulse, 90. The patient was not in a typhoid condition. She complained only of occiput headache, and pain and stiffness in the back of the neck, general sensitiveness, and twitching of the extremi-

ties. On examination, he found her to have marked photophobia, a very stiff neck, which was very sensitive to the touch, as was the occiput and spine, and there was marked general hyperæsthesia. There was no ileo-cæcal gurgle, nor was the abdomen more sensitive than the rest of the body. She had had no eruption, nor diarrhœa, the stools being normal, and assimilation of light food was apparently perfect. The absence of common symptoms of enteric fever, and especially the remission of the temperature, together with the marked prominence of nervous symptoms from the start, led Dr. Amidon to favor a diagnosis of cerebro-spinal meningitis. He gave a bad prognosis, and advised that a close watch be kept for an eruption, and also for enteric symptoms. December 8th, the temperature in the morning was 100.6° F., and at night the same.

December 10th.—With a rise of temperature came a rash which Dr. Currier said was bright and scarlatiniform, and covered *every part* of the body, and lasted several days.

December 21st.—The patient developed an acute bronchitis.

December 26th.—The temperature was normal, and remained so or subnormal *one week*.

January 1st.—She was overfed, and vomited. In the next few days the patient developed indubitable symptoms of septicæmia, with a very irregular temperature (higher in the morning) and frequent chills. These symptoms subsided, and on January 10th Dr. Currier considered the patient again convalescent.

January 11th.—She died suddenly of an immense intestinal hemorrhage in the eighth week of her illness. On autopsy the spleen was found to be about four times its usual size, dark and friable. The ileum and colon were nearly full of dark fluid blood. The ileum was the seat of many entirely healed Peyerian ulcers, and many unhealed ones, from one of which, about eighty centimetres from the valve, the fatal hemorrhage had occurred. The cæcum and the ascending and transverse colon were the seat of small, round, elevated ulcers, many of them covered with grayish protruding sloughs, which evidently consisted of necrosed solitary follicles and the superjacent mucous membrane. The peritoneum covering the large ulcers

in the ileum was covered by an organized fibrinous exudation having a punctate appearance.—*N. Y. Med. Record*, Feb. 26, 1887.

A Precocious Suicide.—Last week a youth named Stopford, only fourteen years of age, shot himself. In explanation he left behind him a few lines of writing, in which he said he "was gone to meet the great mystery face to face." It would be interesting to know more of this youngster's moral training and antecedents, together with the family history. The age of puberty is generally an emotional epoch, with boys as well as with girls, and one phase of this emotional period is an extreme depression, sometimes amounting to a *nausea vitæ*. It is about this age that children begin to be brought face to face with the hard facts of life. Death, want, ingratitude, possibly often seen before, then assume a greater reality and become tangible entities. Lads who, from circumstances, training, or heredity, are wanting in force of character, are sometimes unable to withstand these periods of depression, and become sullen, morose, or decidedly melancholic. As they get older, habit and reason fortify them against such attacks, from which they may remain free until, broken down by ill-health, excesses, or worry, their powers of resistance are so far enfeebled as to open the door to melancholy, from which they rally less readily. Lads who suffer from symptoms of this disordered psychical condition, require, as a rule, but food and exercise in order to overcome it. A little hygiene will often work wonders, especially if combined with a change of air. The more serious cases require a careful moral training in experienced hands, otherwise their intellectual powers may suffer even to the extent of extinction. In no case should they be treated with contempt or harshness, since their condition is thereby only intensified.—*Med. Press*, Feb. 9, 1887.

Suicide by Dynamite.—Some people are dissatisfied with the methods of suicide consecrated by immemorial usage, and prefer to make use of agents which modern science has placed at their disposal. Dr. Zalaski has recently published two somewhat curious cases of this description. In one, a man, on being arrested for poaching on fish preserves by means of dynamite cartridges, attempted to commit suicide with one of them. He

placed it under his chin, but the effect of dynamite explosions being more marked downwards than upwards, the only result was to blow off his right hand, damage the left hand, and mutilate his face. Number two was more successful. He lay down on the ground, placing the cartridge on his chest. After five successful attempts to light a match, the sixth took fire and exploded the cartridge. The thorax and abdomen were completely emptied of their contents, and the corresponding parts of the vertebral column and ribs were also missing. The other parts of the body were not injured.—*Med. Press*, Jan. 26, 1887.

PATHOLOGY.

Firket (Ch.) on the Anatomical Factors Involved in Tubercular Inheritance.—Transmission of a disease from mother to fœtus is only observed where the blood is infected as in malignant pustule, typhus, small-pox and syphilis.

In chronic, primary, pulmonary tuberculosis the anatomical proofs of the presence of a parasite in the blood are wanting in more than one half the cases. When this infection is observed it progresses slowly and interruptedly, in every way different from the infection of malignant pustule. A case of more complete infection is seen in acute miliary tuberculosis.

In most cases of chronic pulmonary phthisis there is no reason to suppose that there is a parasitic infection of the blood, a condition essential to a parasitic infection of the fœtus through the placenta.

Congenital tubercular infection by the placenta should be considered possible, and appears to explain certain cases of tuberculosis developed primarily outside the lung. But congenital tuberculosis has no predilection for the lungs while primary tuberculosis has, and this fact goes to prove that primary pulmonary phthisis is not ordinarily due to a congenital infection through the placental blood.—*Rev. de Méd.*, Jan. 10, 1887.

Weill (E.) on Sudden Death in Pleurisy.—The lesions found in cases of sudden death from pleurisy are: thrombosis or embolisms of the heart and pulmonary artery, œdema of the opposite lung, changes of the myocardium, the latter being only recognizable to the microscope. Cases of

sudden death attributed to functional troubles, such as syncope, displacement of the heart, torsion of the vessels, capillary embolism of the brain, etc., should be received with some reserve.

More suddenly fatal cases have pleurisy on the right than on the left side. Such cases may or may not have the following symptoms: attacks of dyspnoea, premonitory syncope, irregular pulse, and cardiac displacement. Death often occurs when every thing is apparently progressing favorably, and generally follows a motion or effort.

Treatment, of course, is powerless when lesions of the myocardium or thrombosis exist, but the prophylactic treatment is thoracentesis.—*Rev. de Méd.*, Jan. 10, 1887.

Augier on Cancer of the Œsophagus and Purulent Pericarditis.—The author could find but one similar case—that of Reynaud—and in that the pericarditis resulted from a direct perforation.

In M. Augier's case the pericardium was distended with a half litre of pus; the pericardial sac was nowhere perforated, but on examining the Œsophagus it was found the seat of an epithelial ulcer which had produced a pericæsoophagean abscess. The pericarditis was undoubtedly produced by contiguity, and is of especial interest because this complication caused death. The cancer was only slightly developed, there being no dysphagia or cachexia.—*Four. des Sci. Méd. de Lille.*, Feb. 25, 1887.

Acute Spreading Gangrene.—It is not often that examples of this terrible and fatal disease are met with, improved methods of treating wounds and the wounded having almost effectually banished it from the list of surgical accidents during treatment. A short account of a case, which was admitted under the care of Mr. Sydney Jones at St. Thomas' Hospital, will therefore be of interest. The patient, a fairly healthy-looking man, aged forty-three, a gardener, who said he had previously enjoyed good health, fell, on Tuesday, Jan. 25th, and ran a rusty spike into his left leg, about four inches below the knee, making a long punctured wound upwards and backwards, wounding a vessel in the position of the anterior tibial artery. The hemorrhage appears to have been easily arrested, and the man was sent home and put to bed by his medical attendant. He suffered severe pain in the leg until the Thursday morning, when it began to swell

and the pain ceased ; the swelling rapidly extended and the leg became discolored. On Friday mid-day he was sent to the hospital, and was then very ill, but apparently unaware of his serious condition. The leg was swollen from the foot almost up to the groin, and emphysematous crackling extended, chiefly on the outer side of the thigh, to the hip, and downwards over the foot, which was cold and without sensation. The leg was gangrenous, the region of the wound very tense, cold, and purplish-black, with vesication. Above the knee there was brownish pigmentation of the skin, and this, like the oedematous swelling of the thigh, was most marked on the lateral aspects. His tongue was dry, pulse rapid and compressible, and examination of the urine showed the presence of much albumen. Amputation above the middle of the thigh was performed soon after admission, but the patient, who did well for a time, died somewhat suddenly on the following afternoon, four days after the receipt of the injury. There was slight emphysematous crackling in the subcutaneous tissue of the stump, and tenderness along the femoral vein on the morning after the operation.—*Lancet*, Feb. 5, 1887.

Pyæmia after Extraction of a Tooth.—Dr. Zawadski mentions in a Polish journal a case where the extraction of a lower wisdom tooth in a man, aged forty-six, by a "feldsher," was followed by a fatal result. The day after the operation the soft parts in the neighborhood began to swell, then followed severe headache, a rigor, and fever, death occurring on the nineteenth day. At the necropsy, purulent inflammation of the dura mater of the base on the left side was found, and purulent thrombi in the cavernous and superior petrosal sinuses. The soft parts near the angle of the lower jaw were infiltrated with pus, and there were broken-down thrombi in the neighboring veins, also metastatic abscesses in the lungs and spleen.—*Lancet*, Jan. 29, 1887.

Lancereaux on an Autopsy in a Case of Phlegmasia Alba Dolens.—There was a phlebitis of the uterine sinuses propagated to the utero-ovarian veins and thence to the renal veins ; from there the phlebitis had involved the hypogastric veins, the internal iliac, and the inferior vena cava. What was particularly interesting was the fact that the inflammatory process had been transmitted to the arteries ;

the path of transmission being from the renal veins to the renal arteries and then to the aorta, in this way spreading against the current of blood instead of with it as happens in the veins.—*L'Union Méd.*, Feb. 3, 1887.

Mettler (L. H.) on Gangrene After Typhoid Fever.—The only approach to any thing like an adequate account of this subject that I have found in English is the "Toner Lecture" delivered by W. W. Keen in February, 1876, before the Smithsonian Institute. In the hands of the French writers, however, the subject has received most exhaustive treatment.

I have notes of two cases, which differed somewhat, however, both in their etiology and pathology, so far as the clinical observation could determine, for it was impossible to obtain an autopsy in either instance.

The first was that of a little girl, ten years of age, who had been under the care and successful treatment of a physician of this city during a long and severe attack of typhoid fever. The child's parents presented a good family history, and previous to the fever the patient had always enjoyed the best health. Convalescence had become fully established, and the child began to mingle again with her playmates in the open air, when one night she suddenly complained of a cramp with excruciating pain in the calf of the right leg. The family physician was summoned early the next morning, and in the course of the next twenty-four or forty-eight hours discovered the following signs of arterial obstruction and approaching gangrene : the skin grew dark and appeared unhealthy, and later exhibited a strong tendency to suppuration ; the sensitiveness of the part was so intense that the slightest touch caused the child to scream with agony, this hyperæsthesia extending even to the tips of the toes, but gradually diminishing as the mortification became more pronounced ; the local temperature below the knee was lower than normal, while the constitutional temperature remained as in health except at night, when it rose slightly ; the pulse was feeble, but regular ; no signs of endocarditis or special heart-lesion of any sort ; the general appearance of the patient was anæmic.

When I first had the opportunity of seeing the case, which was several days after the first appearance of these signs, the gangrene had made considerable progress and

the line of demarcation was becoming well marked just below the knee. After the usual routine treatment for ordinary gangrene had been tried without any apparent improvement, it was finally decided upon to amputate, which operation was performed by Professor Pancoast, at the knee-joint. Six weeks later the child died of exhaustion and impaired vitality.

The second case, though beginning as a *phlegmasia alba dolens*,—a sequel comparatively frequent after typhoid,—is nevertheless interesting as having shown just before the death of the patient a similar tendency to gangrene, and consequently an implication of the femoral artery as well as the femoral vein. The patient was a woman upward of seventy years of age, whose right leg became swollen and oedematous during the course of the fever.

Very soon, small, rounded sloughs made their appearance here and there along the front of the thigh, while the limb below the knee began to assume the dark appearance previous to the onset of gangrene. Death from exhaustion and the effects of the fever occurred, however, before the gangrenous condition had made itself more pronounced. Compared with the former case, this one was not so striking, since the age of the patient, with its attendant atheromatous condition of the arteries and senile complications, affected more or less the etiological aspect of the gangrene itself. There was no autopsy.

Gangrene as a sequel of typhoid fever is due to mechanical obstruction of an artery producing dry gangrene, or of an artery and vein producing moist gangrene by coagulation of the blood; and that this coagulation, while powerfully assisted by causes of a mechanical nature, is primarily due to an arteritis and abnormal state of the endothelium, brought about by the irritating action of the intense fever-poison floating in the blood.—*Med. Times*, Feb. 19, 1887.

On the Significance of Enlargement of the Supra-Clavicular Lymphatics.—Troisier¹ believes that this sign is present not only in cancerous affections of the œsophagus, stomach, mediastinum, pleura, and lung, but also with any visceral cancer supra- or infra-diaphragmatic. He has seen this glandular enlargement in a case of cancer of the uterus.

Férol² has seen involvement of the glands in both axillary spaces and in the right supra-clavicular furrow in a case of cancer of the stomach.

Millard³ reports a case similar to the last.

The editor has been able to make out distinct enlargement and induration of the supra-clavicular lymphatics on the left side in a case of cancer of the sacrum and lumbar spine with nodules in the liver, lungs, and kidneys.⁴

Kales (J. W.) on Epithelioma of the Auricle.—A male, sixty-five years of age; his father, grandfather, and some others of the family had died, and a brother has since died, of cancer. The patient first noticed a small scale on the upper portion of the helix of the left ear. From time to time scales were removed, and the cancer doctor applied his caustics. The disease was not cured, nor did the caustics do more than stimulate the growth. The application of the knife was refused. The growth of the epithelioma continued for about five years without affecting the health of the patient. Then it suddenly commenced to grow very rapidly. In two months the whole auricle was involved, and the disease was extending along the external auditory canal. The patient rapidly declined in health. The cancer in a few weeks involved the middle ear, and death claimed its victim. I have seen a large number of cancers, but I never saw one do its deadly work more rapidly than this epithelioma of the auricle.—*N. Y. Med. Record*, Jan. 29, 1887.

Napier (L.) on a Foliaceous Fœtus.—Mrs. M'K., ætat. thirty-six, married July, 1874. Six previous pregnancies. Her mother had twins twice. Both her grandmothers had twins twice. Patient menstruated last in February, 1886. Confined naturally on 20th October, 1886. The points of interest in the case were, that both the fœtus shown and the mature healthy living fœtus were confined in one amniotic sac. No trace of placental connection existed between the atrophied fœtus and the placenta, except a certain thickening of the amnion near the fœtus, which might probably have been the remains of a separate imperfectly formed placenta. Pressure may have caused ab-

¹ *La France Méd.*, Oct. 26, 1886.

² *L'Union Méd.*, Oct. 26, 1886.

⁴ *N. Y. Med. Jour.*, Feb. 26, 1887.

¹ *La France Méd.*, Oct. 26, 1886.

sorption of the chorion, and the fœtus would in this way perish. In the placenta and membranes shown there was no sign of disease or insufficient development, so that the case bore out Guillemot's contention, that death in these cases was explained by pressure and not by primary placental disease or detachment, as suggested by Cruveilhier, Caseaux, and Tarnier. The fœtus, which was a most excellent example of the variety, was matured to about 2½ to 3 months.—*Edin. Med. Jour.*, Feb., 1887.

Reynolds (E. S.) on Changes in the Spinal Cord and Peripheral Nerves after Amputation.—Having briefly referred to the history of the subject, and especially to some recent observations made by Friedländer and Krause, he pointed out that the changes in the case which he had investigated consisted in a simple atrophy of the majority of the fibres in the nerve-trunk of the amputated leg, with increase of lymph-spaces and connective tissue, and that this change could be traced up to the cord, principally in the posterior nerve-root, but also in the anterior nerve-root. In the cord the changes were limited to the lumbar region, and consisted of a slight decrease of the posterior horns and columns, and a more marked decrease of the anterior horns, affecting the number and structure of the cells in all the groups, but especially in the postero-lateral and central groups. Clarke's column was not affected.—*Brit. Med. Jour.*, Feb. 26, 1887.

Ernst (H. C.). An Experimental Research upon Rabies.—His experiments were performed with three objects in view: First, to determine whether or not there was such a thing as a virus of rabies; secondly, if there is such a virus, does drying at an even temperature modify its strength? thirdly, does the inoculation of such modified virus afford immunity against the inoculation of a stronger virus?

The different series of experiments relating to these various points were then given in detail. The animals used in most of the experiments were rabbits, although guinea-pigs and dogs were also employed.

The following conclusions were reached:

1. That there exists in the cords and brains of animals inoculated in Pasteur's laboratory a *specific virus* capable of the production of similar symptoms through a long series of animals.

2. That these symptoms are produced with absolute certainty when the method of inoculation is by trephining the skull and injection under the dura mater; with less certainty when the inoculation is by subcutaneous injection.

3. That the strength of this virus is lessened when the cords containing it are removed from the animals and placed in a dry atmosphere at an even temperature.

4. That the symptoms produced by the inoculation of this virus only appear at a certain period of incubation, distinctly shorter when the inoculation has been done by trephining than when done by subcutaneous injection.

5. That injections of the virus modified in strength by drying, and in the manner prescribed by Pasteur, exert a very marked protective influence against an inoculation with virus of full strength.

6. That a very moderate degree of heat destroys the power of the virus entirely, whilst prolonged freezing does not injure it.—*Med. Times*, Feb. 19, 1887.

DISEASES OF THE NOSE, MOUTH, AND THROAT.

ABSTRACTS AND SELECTIONS

By C. H. KNIGHT, M.D.

Wright on Some Forms of Nasal Obstruction (*Manchester Med. Chronicle*, July, 1886).—1. *Ecchondrosis*, or hyperchondrosis traumatic, spontaneous, or congenital, distinguished from deviation of the septum by examination of the opposite naris, and from mucous thickening by its hardness and sharp outline. Treatment, removal.

2. Deviation of cartilaginous septum. It may be congenital, though this is usually of the bony septum. It may result from fracture, or dislocation of either the ethmoid and vomer, or of the nasal spine of the upper jaw. Perichondritis may cause softening and subsequent deviation. Treatment, Adams' operation.

3. Adenoid postnasal vegetations are a frequent cause of nasal obstruction. A case is cited in which both nasal cavities were filled with adenoid vegetations, attached mainly to the septum. They were removed by scraping. Attention is called to a peculiar form of enlarged tonsil, the hypertrophy extending upwards and outwards between the pillars of the fauces and

the layers of the soft palate. The vulsellum and bistoury are required for their removal.—*Journal of Laryngology and Rhinology*, Jan., 1887.

Two Cases Illustrating the Diagnosis and Treatment of Foreign Bodies in the Nose.—In the *Glasgow Med. Jour.* for March, 1887, Mr. J. M. Hunt suggests the following rules in the management of cases of this class.

I. In all cases of discharge from the nose (especially if fetid or unilateral), thoroughly cleanse the nasal cavities by means of sprays, syringing, or forceps, as a preliminary step.

II. Examine the nasal fossæ completely and carefully by means of speculum and mirror. It is not sufficient merely to raise the tip of the nose with the thumb and look in. You will see very little indeed by such a method, especially in children. If you have no nasal speculum, make one by bending a common hair-pin about an inch from its rounded end, or use an ear speculum.

III. Having detected a foreign body, do not try to remove it by douching through the opposite nostril, as there is danger of fluid entering the middle ear by the damming back of the current on the obstructed side. This is no merely theoretical objection.

IV. Where the foreign body presents a sharp edge, extraction is best managed by forceps. Since a rounded body, especially if covered with mucus, will probably slip from the grasp of the forceps, it is best removed by passing a bent probe or scoop behind it and dragging it forwards.

The above rules apply equally to the removal of foreign bodies recently introduced. The *skilful* use of forceps, or probe, is even less objectionable than the "pinch of snuff" treatment, or any of the other ingenious but disagreeable methods usually recommended. These reached a climax in a recorded case, where an emetic was administered and the mouth held so as to wash out the foreign body by means of the contents of the stomach!

Cocaine is of great value in these cases, not only in reducing the sensitiveness of the mucous membrane, but also in contracting the spongy tissue over the turbinated bones, thus facilitating both examination and extraction.

Salivary Fistula Cured by the Galvano-Cautery.—Dr. George Buchanan

relates a case of salivary fistula, resulting from a carbuncle, situated on the left side of the neck, and extending over the parotid region. No attempt had been made to close the opening. A fine cautery point was passed a short distance into the orifice of the fistula and heated by a Faure's accumulator (see *Lond. Lancet*, July, 1881). In two weeks the eschar came off. For a few days there was slight escape of saliva, but ultimately the fistula closed.—*Glasgow Med. Jour.*, Feb., 1887.

In an article in the *Lyon Méd.*, Jan. 9, 1887, after referring to the investigations of Tussaud in this direction, Mollière divides salivary fistulæ into two classes: (1) Those communicating directly with Steno's duct; (2) those opening into one of the branches of the duct, and hence corresponding to a single lobule of the parotid gland. The former are generally situated over the masseter muscles. For their cure plastic operations have generally been advised. Mollière believes they may generally be cured by enlargement of the buccal orifice of the duct and dilatation of the canal. The "canalicular" fistulæ usually open behind the posterior border of the masseter, and they have been generally considered incurable. A case is related in which such a fistula was closed by injections of aseptic oil, with a Pravaz syringe, after gradual dilatation of the main duct. The fistula was the result of erysipelas and extensive sloughing after puncture and caustic injection of a parotid cyst. Six injections of oil, at intervals of one week, were followed by gradual atrophy of the lobule of the gland, drained by the fistula, and in a little more than two months, escape of saliva by the fistulous track entirely ceased.

Submaxillary Calculus.—Collis Barry reports a case of interest on account of the unusual size of the calculus and the gravity of the symptoms. Submaxillary swelling and shooting pains had existed for eight months. Soon the general condition began to deteriorate, and rapidly became reduced to an alarming degree. The concretion could be easily defined in the right submaxillary gland, about the size of a small walnut. Pressure upon the gland caused a few drops of purulent discharge to appear at the mouth of Wharton's duct. There was no concretion—a somewhat unusual fact in these cases—at the mouth of the duct, and there were no enlarged cervical glands. Owing to the

depth of the mass, removal by the mouth was impracticable. Accordingly, the entire gland, together with the calculus, was removed by an external incision. Recovery was complete in three weeks. The stone was phosphatic, and measured about one inch by half an inch. The writer believes it to be the largest on record occupying so deep a position.—*London Lancet*, Feb. 19, 1887.

In the *Virginia Med. Monthly*, Feb. 18, 1887, Dr. B. M. Walker reports a case of salivary calculus occurring in his own person, and attended by the most alarming symptoms, at one time tracheotomy seeming unavoidable. Premonitory symptoms had been noticed twelve years before. The mouth of Wharton's duct had been slit up, but the precise nature of the condition was not recognized until the spontaneous expulsion of calculous masses composed of phosphate of lime, after which rapid improvement followed.

Macro-Glossia.—At a meeting of the Cambridge Medical Society, Mr. Francis read the notes of a case of macro-glossia, which had been under the care of Professor Humphry in Addenbrooke's Hospital. W. M., male, aged five months, was admitted on September 1, 1886. The tongue was too large at birth, and had been gradually increasing in size ever since; the protruded part measuring $1\frac{1}{2}$ inches long in the middle line, and $1\frac{1}{2}$ inches broad at the base, and being symmetrically enlarged in all its dimensions. There were two deep antero-posterior furrows on the surface, parallel with the edges of the tongue, and meeting just behind the tip. There was no evidence of glossitis, and no hemorrhages in the mucosa; there were no teeth, no deformity of the lower jaw, no evidence of lymphangiectasis of any description elsewhere, nor any deformities. There was no history of mental disease, nor deformities, nor struma in the family. The child died suddenly a week after admission; the temperature, which had been irregular before, suddenly rising to 108° F. There was a little difficulty in swallowing, but no interference with respiration. On microscopic examination it was found that the papillæ were much enlarged, abnormally vascular, and covered with a thick layer of cuticular cells. The submucous lymphatics were enlarged here and there, and the lymph-canalicular system of the muscle-bundles were especially dilated, but no

cysts or hemorrhages were seen.—*Brit. Med. Four.*, Feb. 12, 1887.

Three Cases of Perforation of the Velum Palati.—The interest of these cases, occurring in the practice of Trélat, and reported in the *Four. de Méd. et de Chir. Prat.*, Jan., 1887, rests in the fact that each was due to a different cause. In one the condition resulted from syphilitic ulceration due to hereditary disease. In one it was due to strumous ulceration. The third case was an example of an almost unique accident—namely, perforation by an acute abscess of the velum. Subsequently, a second abscess was followed by a similar result.

Incisions in Tonsillitis.—J. Walker Downie writes to the *Brit. Med. Four.*, Feb. 26, 1887, in reply to the views expressed by Dr. Chas. Maclean in the same journal of Feb. 5, 1887. The latter recommends "a large incision," apparently whether pus may or may not be detected. Downie, on the contrary, reserves *incision* for the stage of suppuration. However, he advises scarifying in the early stage, with quaiacum and aconite, and soothing, moist inhalations. When an incision is required the bistoury should be directed upwards and inwards, for the purpose of avoiding the carotid artery. In the cases of hemorrhage reported the bleeding was mainly from the tonsillar branch of the internal carotid, or from the ascending pharyngeal artery.

Acute Tubercular Pharyngitis.—Ariza describes a case of this kind occurring in a young physician. Several small red growths sprang from an ulcerated surface on the anterior pillars. Two or three whitish granules, of the size of a pin's head, were seen on the pharynx and another on the base of the uvula. The patient was in delicate health, aphonic, and suffered greatly from odynphagia. Tubercle bacilli were abundant, and although the appearances were by no means typical, the diagnosis of acute tubercular pharyngitis was adopted. Ariza infers from this case that (1) acute miliary pharyngitis is rare; (2) there may be exceptions to the rule that the course of the disease is progressive and its termination fatal; (3) the appearance in different localities of the lesions may not correspond in point of time to the classical descriptions which have been given; (4) it is curable.—*Four. of Laryngol. and Rhinol.*, Feb., 1887.

In the *Rev. Mens. de Laryngol.*, etc., Feb., 1887, reference is made to a case reported by de Renzi, of tuberculosis and syphilis of the larynx and pharynx, without pulmonary lesions. The laryngeal secretions were found to contain tubercle bacilli. (The presence of bacilli in the sputa derived from the larynx may be very delusive evidence of primary laryngeal disease, unless extraordinary pains are taken to exclude the possibility of their conveyance thither from the lungs. It is doubtful whether this can in any way be certainly accomplished, and it must be admitted that the physical signs of deep-seated or incipient lesion of the lung are often too obscure to justify a positive exclusion of pulmonary disease. Under these circumstances the number of well-authenticated cases is still too small entirely to banish skepticism regarding the possibility of *primary* laryngeal tuberculosis.)

The Negative Value of Lactic Acid in the Treatment of Tubercular Laryngitis.—The claims made for this agent in tubercular laryngitis have naturally led many to resort to its use. Naturally, too, disappointment has been the experience of some. R. Masini has not only failed to obtain the results met with by Krause, Hering, Jélinck, and others, but he considers the acid in the strength recommended (20 % to 80 %) actually dangerous, on account of the possibility of violent spasm of the glottis and in consequence of the extreme degree of inflammatory reaction. His preference is strongly in favor of ethereal solutions of iodoform in these cases. (The idea suggests itself that Masini may have overlooked the necessity of preliminary training of his subjects. It is, of course, undesirable to bathe the larynx with the acid. In many cases it is only by the most patient education of the larynx, combined with strong solutions of cocaine—20 %,—that we are enabled to limit the application to the ulcerated surface. Masini's experience with disastrous effects of the acid must be looked upon as exceptional, and it is to be hoped that it may not discourage the further use of the drug with proper precautions).—*Rev. Mens. de Laryngol.*, etc., Feb., 1887.

In the *Med. News*, Nov. 13, 1886, Dr. G. W. Major confirms the results obtained by Krause, in the use of submucous injections of lactic acid in the earlier swellings, and œdema of laryngeal phthisis. Fifteen to

twenty minims of a 20 % to 30 % solution are inserted at one sitting by means of Krause's modification of Hering's syringe. In the ulcerative stage Major regards local applications of the acid as the most speedy and effective method of treatment.

SURGERY.

Atkin (Charles), on Erasion in Surgical Practice.—Under this head the author includes scooping, gouging, picking, scraping, etc., and writes a rather lengthy article to, very properly, strongly advocate its use in tuberculous affections of bones and joints, in tuberculous ulcers and sinuses followed by the free use of iodoform.

"Cold abscesses," he says, "when apparently unconnected with bone or gland disease, seem peculiarly adapted to this method of treatment. The walls of the abscess cavity consist of two layers—the outer, which is simply condensed areolar tissue, and an inner (the old membrana pyogenica) of loose granulation tissue in which tubercles abound. This violet or yellowish-gray membrane has an uneven villous appearance, and is easily removable. In this last particular it differs from the lining of a suppurating gumma, which is intimately connected with surrounding tissues."

Its use is especially valuable in chronic ulcers of the leg with pale, indolent granulations, or where there are no granulations covering the base.

The author disapproves of the use of the curette for scraping out the cavity of the tympanum for ulcerative otorrhœa, as has been lately recommended, thinking that there is too much danger of injuring the auditory bones.

Much valuable time can no doubt be saved by using the method advocated to replace nitrate of silver and similar caustics in the removal of exuberant granulations or diseased tissues.—*The Medical Press*, Dec. 8, 1886. G. B. P.

Dennis (F. S.) on Laparotomy in the Treatment of Spontaneous Gluteal and Sciatic Aneurisms.—The internal iliac artery has been tied four times for spontaneous gluteal aneurism, the author says : Three of these aneurisms occurred in his own service in the past year, and one in that of Dr. Chew, of Alabama.

Case 1. Woman, aged sixty. Had double gluteal aneurism ; one had existed one and

a half years; the other about a week. Feb. 18, 1886, abdomen opened under strict antiseptic precautions from umbilicus to symphysis pubis. Right and left internal iliac arteries then ligated with catgut after removal of pelvic viscera as far as was necessary.

Patient died on fourth day from suppression of urine. Autopsy showed no peritonitis, kidneys showed a mild grade of diffuse parenchymatous nephritis. "The suppression of urine was doubtless due to acute congestion produced by ligation of the internal iliac arteries."

Case 2. (Dr. Chew). Male, aged forty. Pulsating tumor in right gluteal region for about three months. Had been confined to bed for four weeks on account of pain and muscular spasms. June 15, 1886, abdomen opened by "the usual curved lateral incision." Part of intestines removed from cavity and the internal iliac was then ligated. The wound healed by first intention and the distressing symptoms at once ceased and patient made a good recovery.

Case 3. Woman, aged eighteen. For many years had noticed that the left buttock was larger than the right, but had no trouble from it until five weeks before the operation when she began to have much pain.

Sept. 8, 1886, incision in median line from above umbilicus to within two inches of symphysis. Intestines removed, artery ligated with catgut.

Wound healed, almost wholly by primary union, and there was no return of pain.

The author considers this method of ligation the internal iliac safer, easier, and quicker than that of Abernethy or Sir Astley Cooper.—*Med. News*, Nov. 29, 1886. G. B. P.

Page, on Diffused Traumatic Aneurism of the Anterior Tibial Artery of Ten Weeks' Duration; Attempted Ligation; Amputation.—The patient was a boy of sixteen. Ten weeks before admission to the hospital he was stabbed with a penknife in the left leg at the junction of middle and lower thirds, about one half inch outside the crest of the tibia, in a direction backwards and inwards. There was free hemorrhage. The patient was kept in bed four days on account of a swelling at the seat of injury. The wound healed but three weeks from time of injury. Severe pain came on and the swelling increased. Poultices were applied, and two weeks later an incision was made and the

clotted blood turned out. From this wound there was free hemorrhage on the day before admission. One week later there was another hemorrhage, and the swelling, which occupied the lower third and half of the middle third, was opened and the anterior tibial artery sought. It was not found. There was pulsation in the posterior tibial artery at the ankle, none in the anterior. The tibialis anticus muscle was stripped from the tibia which was slightly eroded, and several inches of the interosseous membrane was lost. "The leg was elevated and dressed." Hemorrhage recurred at night and the leg was amputated through the middle third. Three weeks later hemorrhage again occurred through the incision and the wound was reopened, a small artery tied, and a piece of necrosed bone removed from the tibia. From that time the patient did well.—*The Lancet*, March 12, 1887. G. B. P.

Jackson (Vincent) on Rupture of the Popliteal Artery and Vein; Amputation; Remarks.—The patient, a miner, aged twenty-one, twenty-four hours before admission, while working in a coal-pit, was struck and knocked down by a mass of falling rock. The right thigh, knee, and leg began to rapidly swell, and there was severe pain.

When admitted, the right (injured) limb measured three and one half inches more than the left at the calf, four and one quarter inches more over the patella, and one and three quarters more at lower third of the thigh.

There was much ecchymosis behind the knee and calf. The foot and leg were much colder than those of the sound side, and the foot was of a blue color. No pulsation in anterior or posterior tibial arteries. There was no fracture or dislocation.

Twelve days after the receipt of the injury, the foot and lower part of the leg were gangrenous, and the limb was amputated through the lower third of the thigh.

The patient made a good recovery. The removed limb was dissected and a complete transverse rupture of the popliteal artery and vein found opposite the centre of the popliteal space. The popliteal nerve was not injured. There was much extravasated blood between the muscles and beneath the integument.

Rupture of the popliteal artery and vein without external wound is a rare injury. Complete rupture of the artery alone is un-

common but more frequent than rupture of both vessels. The treatment is to ligate the ruptured ends of the vessels, or to amputate the limb, and the latter is followed by the best results and should be done as early as possible, or when gangrene occurs without waiting for a line of demarcation to form.—*The Lancet*, March 12, 1887.

G. B. P.

Francon on the Circumcision of Diabetics.—Phimosis as a complication of diabetes is quite frequent, and is sometimes one of the first symptoms noticed by patient or physician.

A man of thirty recently entered the Hôtel-Dieu (Lyons), passing 15 litres of water and 150 grammes of sugar daily. For three months he had complained of an incessant itching at the end of the penis, so disagreeable at times as to prevent sleep. Coition was neither troublesome nor painful. Urination was normal except a little dribbling toward the end of micturition. The glans could not be uncovered, and its tip was bluish-red and the seat of several very small superficial erosions. The preputial orifice was narrow, whitish, and resisting, seemingly sclerosed.

The patient was anesthetized and circumcised with most minute antiseptic precautions. The following day he passed two litres of urine containing 150 grammes of sugar.

The wound healed kindly and the patient experienced much relief from the operation, particularly in the way of improvement in general health and in procuring unbroken sleep. The urine still remained saccharine.

From this and several other cases referred to by the author, he concludes that not only is the operation not contra-indicated by the existence of diabetes, but rather that condition is an indication for the relief of phimosis if present.—*Lyon Méd.*, Oct. 24, 1886.

Thiriar on the Analysis of Urine in Abdominal Surgery.—The author, from especial study of this subject, has concluded that the amount of urea is of great diagnostic value in determining the benign or malignant nature of abdominal tumors.

In the case of benign tumors the daily excretion of urea varies from 15 to 25 grammes, never falling below 12 grammes. In the case of malignant tumors of the abdomen the daily excretion of urea is small, being in three cases 4, 8, and 7 grammes

respectively. The author advises quantitative examination of the water in all instances before operating on abdominal growths.—*La Presse Méd. Belge*, Nov. 14, 1886.

Annandale (Thomas) on Internal Derangements of the Knee-Joint and their Treatment by Operation.—The writer reports four cases of displaced semilunar cartilage successfully operated upon by the following method:

"An incision is made along the upper edge of the tibia, on the side corresponding to the cartilage displaced, and it should extend from the border of the ligamentum patellæ outwards or inwards, according to the cartilage affected, for a distance of about three inches. The tissues having been divided, and the synovial membrane exposed, all vessels should be secured before the joint is opened. This having been done, the synovial membrane is incised in the same direction as the external wound, and the parts examined. A blunt hook is then inserted, and hooked round the anterior margin of the displaced cartilage, which is in this way brought into its proper position, and held there while two or three interrupted catgut sutures are passed through it and the periosteum and fascia, over the edge of the head of the tibia. In this way, the cartilage is firmly secured in its proper place. The edges of the external wound are then brought together by sutures, and the dressing and a splint applied."

These four cases bear out the following facts:

"1. That one or other of the semilunar cartilages—most frequently the internal one—is liable to be displaced, and to cause more or less interference with the movements of the knee-joint.

"2. That this displacement may be slight—as is most common—or severe, and that the amount of displacement depends upon the extent of separation of the attachments of the cartilage.

"3. That it is the anterior attachments of the cartilage which are most frequently separated."

The diagnosis he considers is usually readily made, yet it is sometimes impossible to reach a positive conclusion, and in these cases he advises an exploratory incision, if the disability is really seriously interfering with the patient's comfort or usefulness, which will enable one to ascertain the cause of the trouble and at the same time remove it.

The writer also reports three cases of growths in the interior of the knee-joint successfully removed by an incision made as for the fixation of a cartilage.

The first case was that of a woman aged twenty-one who, one year before the operation, had twisted the joint. Since that time had had much pain and limited motion with a tendency of the joint to "catch," and was thus prevented from taking active exercise.

The joint was normal in appearance except for slight fullness just internal to the ligamentum patellæ, at which point pressure caused pain.

On opening the joint the cartilage was found in its normal place, but "a small mass of fatty and fibrous texture was lying over the inner and anterior margin of the cartilage where the fullness existed. This growth was connected to the synovial membrane, and was movable, and could be drawn forward." The growth was drawn forward and stitched to the periosteum on the upper edge of the tibia, to fix it and prevent its passing between the joint surfaces. The patient recovered with perfect motion.

The second case was almost an exact reproduction of the first, but in this the greater part of the growth was cut away before its base was fixed by sutures.

The third case differed from the others in that a movable body could be felt on the outer side of the joint, which, on removal, proved to be a myeloid sarcoma. This case also did perfectly well.

Judging from the results in these three cases, and in others mentioned below, the writer concludes that when such a growth is recognized in a knee-joint, it should be removed or fixed by an operation if there is no other joint disease except synovitis.

In the *American Medical Record* for June, 1886, there is an interesting paper on the subject by Dr. R. F. Weir. Dr. Weir records two cases of his own and one of his colleague, Dr. Bull, in which tumors were removed from the knee-joint. In one case the tumor was composed of "vascular connective tissue, rich in fat and connective-tissue cells." In the second case the growth was a "fibro-sarcoma," and in the third the growth was a "giant-celled sarcoma." Weir also refers to other cases published by Simon, Volkmann, König, and Lauenstein. Barwell ("International Encyclopædia of Surgery") mentions that

he removed two fatty growths from the knee, one being situated upon each side of the ligamentum patellæ. He expresses the opinion that some of these growths are formed in the subsynovial tissue, and gradually bulge into the joint. Volkmann, under the term "lipoma arborescens articulorum," has described a condition of multiple fatty growths having their origin in connection with the fringes of synovial membrane.

The last case in the paper is that of a woman aged fifty-five, who for several months had had pain and stiffness in the right knee-joint, and latterly had noticed that free movement of the joint was prevented by some thing "catching inside the joint." Just outside the ligamentum patellæ a hard body was felt, and an incision parallel to the outer border of the ligament was made, exposing this body, which was an outgrowth of the articulate surface of the femur. It was removed by a chisel, and measured one half inch in length and one quarter of an inch in diameter at the base. The patient was discharged much improved.

It is well known how commonly outgrowths of chronic arthritic origin cause interference with the movements of this and other joints, and it cannot be said that such cases are very favorable for operative interference; but still I think that in cases where a single and distinct growth is causing much pain or stiffness, the question of an operation may be taken into consideration, and the case just recorded proves that the removal of such a growth may be successfully performed, and may also, even if not perfectly relieving the symptoms, improve them. It is not an operation that I would wish to urge very strongly, and the general condition of the patient, the condition of the joint, and his or her wishes—the question having been properly explained—would influence me in advising its performance.

Lastly, in opening the knee-joint for the removal of growths, the incision will be best made over the position of the growth, if it can be felt. Should its exact position not be determined, and the case be one suitable for operation, I would suggest that the incision advised for the fixing of the internal semilunar cartilage be employed, as it was found very convenient in the three cases reported.—*British Med. Jour.*, Feb. 12, 1887.

G. B. P.

DISEASES OF THE EAR AND EYE.

Browne (E.) Supposed Case of Quinine Amaurosis.—A powerful man, aged thirty-four, fell into the water at Shanghai. He took about 30 grs. quinine every two hours. Confusion of hearing followed, and he became deaf. Soon after there was flickering of the sight, and he grew suddenly and totally blind, the pupils of the eye being widely dilated. At the end of six weeks, objects began to be seen in a bright light, and soon after vision completely recovered. Field of vision much contracted, optic disks pale, vessels extremely small, hearing perfect. References to 18 cases were collected showing similar progress of symptoms. First deafness, then blindness, the blindness being more complete than in any other recoverable condition. There was always extreme contraction of retinal vessels. The period of blindness had lasted from three or four to seven months. Central vision reappeared first, and in most of the cases the contraction of the field was permanent.—*Provincial Med. Four.*, Feb. 1, 1887.

A. T. M.

Lee (C. G.) on the Extraction of Soft Cataract by Injection.—Six cases are reported in which the soft cortical matter of cataract was expelled by injection of water, temperature 97° Fahr. The principle has been used before by Dr. McKeown. That operator used a syringe, tubing, and terminals. The author substituted a reservoir for the syringe, to secure a steadiness in the flow, and better control of the force by raising or lowering the reservoir. After the usual sclero-corneal section, iridectomy, and removal of the lens, the terminal or the end of the tube without such appliance was introduced into the globe as far as the iris border opposite the wound, and keeping careful hold between finger and thumb of the tube near the eye the flow is started. The particles of soft lens material are seen to float up and come away. This method does not prove sufficient to break loose attachments between iris and capsule when such exist. Neither would it be well to try this method with young or nervous subjects, as movement of the eye or head would be unfortunate. The amount of vision obtained was very good. In all it

was over $\frac{1}{2}$. Neither was the detention in hospital longer than after the usual operation above.—*Brit. Med. Four.*, Jan. 15, 1887.

A. T. M.

Dujardin on an Eyelash in the Anterior Chamber.—The patient had received an injury to the eye and a wound of the globe. By oblique illumination a foreign body was seen directed vertically in the outer part of the anterior chamber of the left eye. The upper end of the lash was slightly curved.

The author could find but twenty-nine such cases on record.—*Jour. des Sci. Méd. de Lille*, Jan. 7, 1887.

Mets on Recovery from Optic Neuritis.—A woman of thirty-two was attacked with a double optic neuritis. The author could find no cause for this neuritis except anæmia, and he prescribed a tonic treatment with stimulating pediluvia and irritant applications to the forehead. In three weeks both eyes were normal. It was found that the patient excreted thirty-nine grammes of urine a day—a large amount for an anæmic person,—and he attributed the ocular affection to this condition of azoturia.—*Ann. de la Soc. Méd.-Chir. de Liège*, Feb. 1, 1887.

Le Plat on Regeneration of the Aqueous Humor after Paracentesis of the Cornea.—The experimenter punctures the cornea of one eye of a rabbit, and at the same time injects some iodide of potassium hypodermically. He lets the aqueous escape until he finds it containing iodine, and then he allows the anterior chamber to fill, as it will in about twenty minutes. He then enucleates both eyes, freezes them, and estimates the proportion in each. He always finds less iodine in the punctured eye, which he explains by supposing that the aqueous is regenerated from the vitreous, which does not absorb KI. until later. The counter proof is as follows: He operates in the same way, not evacuating the aqueous until two hours after injection, when the vitreous contains more KI., and then the regenerated aqueous is richer in iodine than that of the sound eye. Other experiments have proven that these results are not due to the lowered tension produced by the escape of the aqueous. The author concludes that the aqueous is regenerated in great part from the vitreous.—*Ann. de la Soc. Méd.-Chir. de Liège*, Jan. and Feb., 1887.

PUBLISHERS' NOTES.

Lactated Food.—One of the greatest objections that have been made to the use of the various prepared infant foods upon the market has been their high cost. As it will be a matter of interest to the entire profession to know the comparative costs of the various foods, a careful computation of the cost of each class has been made, prepared according to the directions given for infants.

The so-called milk foods or powders are found to be the highest, averaging to cost, when prepared ready for use, about nine cents per pint; next in cost is a class called Liebig's Food, which average six cents or more a pint; next is a class of farinaceous foods, which cost nearly as much as the Leibig Foods. Below all these is Lactated Food, which costs but four cents per pint, making it the most economical food the profession can use. A dollar package of Lactated Food will give an infant one hundred and fifty meals, or sufficient to last about four weeks.

Lactopeptine.—

SANDY HOOK, CT.

Probably there is no one medicine in our whole practice with whose use we are more familiar, and of which we use so much, as Lactopeptine. In cholera infantum and the summer diarrhoea of children it is simply invaluable, and accomplishes in our hands easier and better results than any other medicine or combination of remedies seems to be able to do.

W. C. WILDE, M.D.

Murdock's Liquid Food.—We have used Murdock's Liquid Food in a number of cases of great debility, and where the stomach was unable to retain any kind of food; in some cases, in fact, the patients were starving to death. The results have been *all and more* than we expected. We think it needs but a trial to prove its worth to every one.—EDITOR, *Peoria, Ill., Medical Monthly*.

Horsford's Acid Phosphate.—There are no substances that play a more important part in animal economy than the phosphates. Every mental exertion induces an augmented waste of the phosphates. Wherever there are functions that seem to be suspended, we may be almost sure to find it occasioned by want of phosphates. Horsford's Acid Phosphate is said by many good authorities to supply that

waste, and to impart new energy to the brain, giving the feeling and sense of increased intellectual power, and toning and bracing up the whole system.

Colden's Liquid Beef Tonic.—

BALTIMORE, Jan. 20, 1875.

I certify that I have used "Colden's Liquid Beef Tonic" largely in debility, febrile and nervous diseases, and that I have found it one of the most reliable of our nutrient tonics now in use or to be found in pharmacy.

JOHN J. CALDWELL, M.D.

71 N. Charles St.

Cod-Liver Oil Emulsion.—The distaste which many patients have for cod-liver oil may be happily overcome by means of a well-made emulsion. Scott & Bowne, of New York, have for many years made a specialty of this preparation, the excellence of which is attested by results known to every practitioner of large experience. These manufacturers have succeeded in combining the oil with the hypophosphites, which affords the physician a palatable preparation of the highest therapeutic worth. The Buckthorn Cordial, brought forward by the same house, is worthy of professional attention.—*Am. Practitioner and News*.

Celerina.—T. R. Dice M.D., Utica, Mo., says: I have been using Celerina the past two years, in neurasthenia and nervous headache, with marked success.

Aletris Cordial.—I am using Aletris Cordial (Rio Chem. Co.) in a case of a lady who has aborted twice. She is now in her sixth month. Every thing indicates she will go to her full time.

J. R. HEREFORD, M.D.

Ferguson, Mo.

Iron-Alum Mass.—For throat disease and Chronic nasal catarrh, taken systematically and as a local application, I find Seven Springs Iron Alum-Mass of Extreme value.

RICHARD LEMON, M.D.

Lynchburg, Va.

Ricord Capsules.—Send to E. H. Truex, 298 Pearl St., N. Y. City, for circular pertaining to this preparation.

Write to the Dean of the New York Homœopathic Medical College for their catalogue.

Palatable Cod-Liver Oil.—The Chas. H. Phillips Chem. Co., 30 Platt St., New York, will send an illustrated circular in regard to their Palatable Cod-Liver (Emulsion), if MEDICAL ANALECTIC is mentioned. See ad. on front cover page.

THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

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WHOLE No. 41.

LEADING ARTICLES.

Warren (J. W.) on the Digestion of "Living" Tissues.—The question is: Why do organisms which manifest such power of digesting and assimilating the material they require, leave quite intact those organs or tissues where these processes go on so actively? Why does the stomach digest various albuminous substances so readily, and yet fail to attack its own walls, containing substantially the same material? Why do the intestines, with their much more varied power of digestive action, remain undisturbed and uninjured by this activity? Why does the pancreas secrete at least three vigorous digestive ferments, and yet work on unaffected by each and all of them? The same question may be urged concerning the various glands of many lower organisms which have a well-defined digestive tract; and the enigma only grows in difficulty and interest as we consider those forms of life where such a differentiation of organs does not appear to be present, and where processes at least analogous to the digestion of higher animals are carried on.

It has been urged that the stomach preserves its integrity, first, on account of its life—by some "vitality"; or, on account of the protection afforded by its epithelium; or, again, because so much mucus is present as to enwrap the food, or cover the surface of the organ; or, finally, because the acid is neutralized by the alkaline blood, the exceeding vascularity of the stomach in the active digestion rendering the acid harmless as soon as it reaches the tissues of the gastric wall. Each of these explanations, alone or in various combinations, has found its defenders; and yet no

one of them, nor all of them together, can be considered satisfactory.

The supposititious protection afforded by the mucus¹ has the least claim upon our attention. This, if it worked by any alkalinity it possessed, could only hinder the proteolytic action by weakening the acid, whose presence is indispensable. If the protection be sought in the coating which is given to the stomach or to its contents, the explanation must at once appear to us to be unreasonable. How could any such coating be assumed to be permeable for acid and pepsine in one direction (that is, towards the mass to be digested), and to permit the passage of digested or dissolved material in the opposite direction (towards the gastric walls), and yet not allow the acid-pepsine mixture to pass with equal freedom.

Should we confine this explanation to the small intestine, with its alkaline digestion, as Claude Bernard seems to have done, a still further and more weighty objection may be found in the fact noted by Frenzel, that insects have no such layer of mucus in their intestinal tract, and yet no self-digestion occurs there during life.

The protection attributed to the epithelium, whether it be thought to lie in its own resistance to digestive changes, or in its rapid renewal, would appear also to be insufficient. It has been found that the epithelium may be quite extensively injured or removed,² and no digestion of the underlying tissue takes place. The reports of cases where sounds and stomach-pumps have produced lesions of the epithelium, appear to be confirmatory of the view that the protection of the stomach is not to be sought in this coating, or, at least, not alone therein.

¹ Cf. Harley: "Contributions to our Knowledge of Digestion." *British and Foreign Medical-Chirurgical Review*, vol. xxv., 1860, pp. 206-214.

² Pavy: *Medical Times and Gazette*, 1863, vol. ii., p. 286. This is an abstract of a paper read before the British Association. See also, Harley, *loc. cit.*

The alkalinity of the blood and the lymph, as a possible defence against the attack of the gastric juices, would, at the first glance, appear to be much more acceptable. The localized self-digestion of ulcerations, or in cancer, might be attributed to altered blood-flow, and consequent lessening of alkalinity. In the marked case of gastromalacia given by Leube and Mayer, and already quoted above, the individual had extensive cicatricial contractions at the pylorus, as well as at the cardia; and these would probably materially alter the blood-supply.

In this connection, however, we may not pass over in silence an observation made, several years ago, by Edinger.¹ He injected a solution of alizarin into the blood-vessels, and inferred, from the color-changes, that the mucous membrane of the stomach has an acid reaction throughout a considerable portion of its substance when active digestion is going on. Unfortunately, his method is not delicate enough to permit a microscopical examination of the tissues.

Even if we accept fully the view that the alkalinity and vascularity of the gastric walls preserve them from digestive destruction, we advance but a little towards a solution of our larger problem. In the small intestines we find a no less active digestive process, and a much more varied one, which is carried on in an alkaline menstruum. If the alkaline blood protect the stomach, what is the power which guards the walls of the smaller intestines?

The oldest explanation is that commonly attributed to John Hunter. This finds the immunity of the digestive apparatus in its "life"—in its vitality.

It was not, however, until the second half of the century had begun, that an experimental refutation of John Hunter's theory was made—at least so far as it concerns the question now under discussion.

It is only about thirty years ago, the reader will remember, that Claude Bernard² found that gastric juice, injected under the skin, digested the subcutaneous

tissues. He saw further, that the legs of a living frog inserted in the gastric fistula of a dog, were digested off to a great extent in about three-quarters of an hour, the rest of the frog remaining alive. A similar experiment was made with snakes. These observations were confirmed by Pavy,³ Harley,⁴ and others; they were extended by the partial digestion of the ear of a living rabbit. It thus became evident that the "life" of the animal could have but little to do with the protection of its digestive canal from proteolytic changes. The external and extreme parts did undergo digestion and the animal was not obliged to die, the very thing Hunter said could not happen.

Frenzel suggests that these experiments really only showed a partial solution of the "living tissues," and did not absolutely demonstrate their digestion—that is, their peptonization. He accordingly tried an artificial digestion of "living" tissues, and arrived at interesting results. Several years ago I made a number of similar experiments, and reached generally the same conclusions as those now printed by Frenzel. I reported my work at a meeting of the Boston Society of the Medical Sciences in the spring of 1883, but published nothing. It seems desirable to note them now as confirming the work of Frenzel and somewhat extending it, and I do so without intending to claim any priority for the method or the results.

Frenzel's experiments were made by fastening a frog on a forked board so that each leg hung in a vessel which contained hydrochloric acid (0.2 per cent.) or acid and pepsine. In the latter case marked changes were soon observable. The skin freed itself in patches, and the flesh gradually disappeared, especially on the parts where the epidermis was removed. In such places the bone was fully exposed in about an hour and a half. The blood-vessels were also affected: the walls burst, the blood exuded and coagulated, and the coagula were finally dissolved. On examination, the liquid in which such a leg hung

¹ Edinger: Ueber die Reaction der lebendigen Magenschleimhaut. *Pflüger's Archiv. f. d. ges. Physiologie*, xxix., 247.

² Claude Bernard: *Leçons de physiologie expérimentale*. Paris, 1855-6. Vol. ii.; Cours du semestre d'été, 1855, pp. 408-9.

³ An account of Pavy's experiment with the ear of a rabbit, as well as his views concerning the pro-

tection afforded by mucus or epithelium, and the importance of the alkalinity of the gastric walls, may be found in his "Treatise on the Function of Digestion," London, 1867, p. 74. The reader may also consult Pavy's paper: "On the immunity enjoyed by the Stomach from being digested by its own Secretion during Life," in the *Transactions of the Royal Society* for 1863. ⁴ Harley, *loc. cit.*, p. 211.

was found to contain peptone—there had been a genuine digestion. The other leg, hanging in acid alone, is said to have shown no special change save that the outer layers of the epidermis were slightly swollen. Where the epidermis had been removed a swelling and softening of the muscles was not observed—nor could such a leg be afterwards digested by pepsin in a neutral solution, as would be expected had the muscles imbibed the acid. It should be added that the experiment was carried on at a temperature of 38° C. Frenzel does not say positively that such frogs remained alive, but it is to be inferred, from the tone of his article, that they did. He also reports that merely moistening an exposed muscle “at a suitable temperature” suffices to bring about an evident digestion. The number of experiments is not given.

My own observations were made on a large number of frogs; altogether about fifty of them participated in perhaps twenty experiments, but some died too early to make their share complete and useful. A detailed account of the methods employed and of the changes perceived may be omitted now, and I will generalize them as much as possible. Originally I only intended to modify Bernard's method for lecture purposes, and the lower legs of the frog hung in test-tubes, which stood in the water bath, whose temperature was fairly constant (38° C). I was thus able to demonstrate that the lower legs could be much softened (or even drop off) and the rest of the frog remain alive—that is to say, the heart was still beating and the muscles of the upper leg responded perfectly to electrical or mechanical stimulation of the nerves. My occupations at the time unfortunately obliged me to leave the experiments unwatched overnight. The results which this long exposure to acid alone produced differ from those of Frenzel in that the muscles were often much softened and even dissolved, but this effect was usually not so intense nor so extensive as where the leg was exposed to acid and pepsine. When, however, such solutions were compared, that produced by the aid of pepsine acquired a rose color with soda and cupric sulphate, which only gave a purple color where acid alone had been active (Biuret reaction). In other words, only the pepsine solution appeared to have really peptonized the muscle. Early in this work it occurred to me that the ex-

posure to so high a temperature could not be a matter of indifference to the tissues. The frog is accustomed ordinarily to surroundings where the thermometer stands hardly ever higher than 15–18° C., and to remove him (or only his legs) suddenly and permanently to a climate where the mercury is always at 38° C., means a change such as would cause us much concern were we to make it *ante mortem*.¹ I accordingly repeated the experiments at room temperature with substantially the same results. Later, further modifications were introduced to lessen the possibility of disturbing the blood flow and the nutrition of the muscles by the hooks and bands which were needed to support the frog comfortably. Cutting the medulla oblongata as well as section of the sciatic plexus was tried, but the outcome of the experiment was the same and in general accord with Frenzel. I may add that control experiments were always carried on at the same time. Finally I followed a suggestion of Dr. H. P. Bowditch and curarized the animals, which enabled me to place the lower legs in little troughs containing the digesting solution. In this way it was chiefly the gastrocnemius muscle which was exposed to the liquid, and this was favored by slitting the skin. By this means I was able to reach some very interesting results. It proved to be possible to digest (or at least make translucent and soft) a good portion of the exposed gastrocnemius, while all the rest of the same muscle was uninjured. That is, the undigested portion was firm and red as in health, and still manifested that perfect irritability which belongs to a sound muscle. It is hardly necessary to add that the other muscles of the leg, the heart, in short, all the rest of the frog remained fully alive. This took place too, it must be remembered, at a temperature in no way unfavorable to the animal's existence or comfort. A more instructive form of the digestion of “living” tissues cannot easily be found. On varying the strength of the acid it was seen that solutions ranging from 0.3 per cent. to 0.05 per cent. were positive in their results. No decided effect, however, was produced

¹ This objection does not seem to have occurred to Frenzel. Pavy, however, may have had it in mind when alluding to “the more powerfully acting stomach of a warm-blooded animal like the dog,” as the weak point in Bernard's experiment with a “cold-blooded reptilian animal.”

by a mixture of pepsine with 0.015 per cent. HCl., which was competent to digest boiled fibrin. It thus appears probable that a local digestion of a living muscle may be produced by pepsine and an acid of such strength that the entire amount of acid employed is less than that which the blood might be expected to neutralize. While I cannot maintain that my experiments were sufficiently numerous to settle this point, especially as I did not have this particular question in mind at that time, the notes made as the experiments progressed suggest a conclusion of this character. I propose examining this point more exactly when I can find time for such work.

I also tried to attack the living muscles in an alkaline menstruum by means of such pancreatic extracts as we then had in the laboratory. The results were either negative or inconclusive, but the ferments at my disposal were not as good as we now have, and I consider this question open for further investigation.

Finally, then, we must admit that we are still far from a satisfactory explanation of the immunity of the various digestive organs with reference to their own ferments while "alive" and the lack of such protection when "dead." It might be suggested that many or all of the ferments come from their glands in a partially inactive condition (in form of a zymogen, as pepsinogen, trypsinogen, and so on), but this consideration would have value only for the glands, and is useless for the stomach and intestine. Frenzel suggests, as Krukenberg¹ had already recently done, that the comparative physiology of digestion may be expected to solve our problem. Possibly the solution will prove to be less simple than we expect, and by showing us how exceedingly varied in principle the processes are which we have been accustomed to lump together under a single name as "digestion," also demonstrate that the safety of the "living" structures immediately involved is due to equally varied causes. Of course no one supposes that the tissues actually remain "alive" when the digestion begins. That part which is to be dissolved "dies" either before or during the digestion, but the direct cause which changes the living complex albumen

molecule with its vigorous resistance to dissolution into some feebler form, making it the victim of any enzyme which may happen to meet it, no man knows with certainty or completeness.—*Boston Med. and Surg. Jour.*, March 17, 1887.

Eggleston (W. G.) on the Treatment of Insomnia by Food, Baths, and Exercise.—The first case of insomnia with which I had to deal, my own case, taught me the utter uselessness of depending solely upon hypnotics for the relief of this condition; and subsequent cases treated successfully by food, baths, and exercise have shown that hypnotics are not only not to be depended upon, but that in many cases they are not required at all, and do more harm than good. I do not wish, however, to be understood as advocating the disuse of hypnotics in all cases of insomnia; my remarks must be taken to apply only, so far as my experience goes, to febrile insomnia, or the insomnia of convalescence from acute diseases, to the condition of sleeplessness arising from long hours of mental activity or excitement, and to insomnia from exhaustion. The two last may often be classed together.

In febrile insomnia there is a greater or less degree of cerebral excitement, which, when active, calls for an exhibition of bromides and chloral. In a still more active stage morphia may be indicated, especially if pain, such as headache or backache, be so pronounced as to demand attention; but as a rule, drugs which interfere with elimination should not be given. On this account paraldehyde is of very great value in some of these cases. In the eruptive fevers, when the cutaneous irritability is so great as to induce insomnia, sleep may be often produced by the use of warm or tepid baths. In many of these cases of febrile insomnia, I have noticed that the patient would often fall asleep soon after the administration of food, and more particularly if a bath was administered just before the food was given.

Wakefulness in these cases, and in many others, may be considered as the symptom of an irritable weakness of the brain or nerve centres. We know that in the latter stages of a protracted illness the condition of insomnia often depends upon the malnutrition of the patient, and that the indication is to furnish material which will delay or stop the processes of malassimilation or disassimilation. The failing power of

¹ Krukenberg: Die eigenartigen Methoden der Chemischen Physiologie. Heidelberg, 1885, p. 20.

the heart, due probably to the same irritable weakness of the nerve centres which causes the wakefulness, demands, as we all know, such diffusible nutriment as the system can assimilate with the least expenditure of force; and hence, we give milk and meat juices, sometimes alcohol, but rarely opiates. There is a tendency, I believe, to rely very much upon hypnotics in these cases, as in all cases of sleeplessness; and I believe this to be wrong. To say nothing of other objections to their frequent use, they disorder the stomach, and in the weakened condition of the patient his system soon falls into the habit of demanding these aids to artificial sleep. There is usually but little positive appetite, and bromides and opiates take away whatever there is.

But it is not alone in the cases of febrile insomnia that the nervous system is in a condition of irritable weakness. It is frequently seen, and I believe it to be the cause of a very large proportion, if not all, of those cases of insomnia from intense mental activity or excitement, and of insomnia from exhaustion. Among hard-working college students, newspaper men, accountants, and men whose lives are given up to literary pursuits, insomnia from exhaustion or excitement is not an uncommon affection; and it is common also in women who have been exhausted by protracted nursing of a sick child or friend, or who have been subjected to some unusual excitement. In dealing with this condition it is not sufficient to say that a complete change of habits must be made. In the majority of cases the patient cannot change his or her habits, and take a long vacation or a protracted voyage; and in the majority of cases this is not necessary.

I have noticed that most students, and women, who are troubled with insomnia are dyspeptic; and, in fact, I rather believe that a greater or less degree of dyspepsia or aepsia, and gastric irritability, will be found in all persons who are much troubled with insomnia. It must be very evident that a course of bromides or other hypnotics will not ameliorate the condition of the gastric or intestinal mucous membrane. It is quite clear also, that bromides will not permanently lessen the degree of nervous irritability which depends on the want of proper food. I have found it not only possible, but comparatively easy to treat cases of this kind without a single dose of

any hypnotic, and without a change of or vacation from work. In some cases one or two doses of bromide of sodium or potassium, or paraldehyde, have been necessary.

In cases of students and women who complain of insomnia, I have usually found that they take but little exercise, that they are constipated, have but little appetite, and suffer with gastric oppression after the main meal of the day, whether it be about midnight or in the evening. They usually drink tea or coffee, sometimes immoderately. If the case has gone on for some time, there is an evident condition of anæmia. The first thing I do is to unload the bowels, and keep them open with cascara sagrada, though to begin with I usually order blue mass. The medicine ordered, as a tonic, is usually either nitro-muriatic acid (equal quantities of nitric and hydrochloric acids and water), or tincture of the chloride of iron 3 ij, Fowler's solution 3 ij, and strychnine gr. j. Two to six drops after each meal (or more), or else Fowler's solution alone. In the majority of my cases with students, I have used small doses of these drugs, and sometimes no medicine except the purgative. They are then instructed to eat before going to bed, having put aside every form of work at least half an hour before bedtime. A formal menu cannot be made out for these cases; they should simply be instructed to eat, and if they are hungry they should eat whatever they want. A glass of milk and a biscuit or a piece of toast is sometimes all that can be taken at first; or a mashed potato buttered. In a short time the night appetite will grow, and the appetite will then need no particular directions. If possible the night meal should be taken in another room than the sleeping apartment, and for men in the city, it will be found advantageous to go out to a restaurant. The idea of going out for something to eat, and having to wait a short time for it will excite the appetite.

Before eating, however, a bath should be taken. I much prefer cold or cool baths, which should be given with a sponge or stiff brush, and the body thoroughly rubbed off with a coarse towel afterwards. The bath need not be more than five minutes in duration. The objection to the warm bath is that the patient is liable to take cold after it, and it is not so refreshing as a cool or cold bath. After the bathing and rubbing, or after eating, a moderate amount of exercise should be

taken. For this a few minutes with Indian clubs or dumb-bells is sufficient. Further than this, the patient should go to bed at the same hour every night, and arise at the same hour every morning.

I have seen a considerable number of cases of insomnia among night men on morning newspapers. These men usually take the evening meal about 6 o'clock, and then often work until 2 A.M. Within the past two years and a half, I have had more than twenty cases of this class, and I have not given a dose of medicine, other than a purgative, to a single one. These patients cannot conveniently stop to take a bath, and then go out to eat. They are instructed to go from the newspaper office to a restaurant, and eat what they want. Here we usually find that the appetite is good. After eating, any thing from half a dozen oysters to a good steak, or as much, in fact, as one would eat for a hearty breakfast, they go home, bathe the face, head, neck, and chest, take five minutes' exercise and go to bed. In each one of my cases of this class, the patient has reported that the treatment was a success from the first.

Since the age of eighteen I have been more or less troubled by insomnia, and nothing has ever given such decided relief as a course of hearty meals just before going to bed. When the temporary insomnia has been relieved by this, I continue the sponge-baths and exercise before going to bed; but sleeplessness often returns after a sustained degree of mental labor and excitement, and is almost immediately relieved by a generally hearty meal before going to bed. At nineteen years of age, while a student of medicine, I was dosed for this condition with every then known hypnotic, without any perceptible effect. Accidentally, I found that after eating late at night I slept well; and I now make it a rule never to go to bed hungry, and always to eat at night when I am in the midst of an unusual amount of work, or engaged in work of an unusually exciting character.

I have had to deal with only two cases of insomnia in old people. In both these cases they had been advised to take a "night-cap" before going to bed. At first the remedy was efficacious, but in a short time it was found that the quantity of alcohol in the "night-cap" had to be increased, or it had no effect, and finally

an excessive quantity of alcohol was demanded. I rapidly diminished the quantity of alcohol as the amount eaten was increased, until, with the aid of a full supper and no alcohol whatever, the sleep was plentiful and much more refreshing than before. I do not know of any thing which will more readily impair a digestive apparatus than alcohol on an empty stomach. Further than this, one runs the risk of inducing the alcohol habit by prescribing it in this way; and it must be acknowledged that the drowsiness induced by alcoholic drinks will not pass into a natural and calm sleep; and an artificial sleep is only demanded when a patient is positively ill. A cup of hot beef tea (made from some good extract of beef) taken just at bedtime, will often be sufficient to cause a good natural sleep.

There is a popular superstition that grown people should not eat just before going to sleep; that it will give them indigestion or "nightmare," or both. I cannot see why adults are so very different in this respect from babies. We know that young children awake at night and must have something to eat before they will sleep quietly; and some children actually fall asleep with a nursing-bottle leaking into the mouth. It may be true that digestion is carried on slowly during sleep, and that the digestive function is less active; but here one need not be in a hurry for the completion of the operation. The average person should be in bed seven or eight hours, which is time enough for the digestion of almost any thing edible. In our American city life I think that digestion carried on during sleep probably has the better chance for thoroughness.—*Four. Am. Med. Ass'n*, Feb. 19, 1887.

Harrington (F. B.) on Hæmospermatisms.—In January, 1885, Mr. J. A., twenty-five years of age, a teacher in one of our institutions of higher education, a single man of good physique and of excellent habits, came for advice because of a slight enlargement of the epididymis of the right side. It caused slight pain after long standing or walking. The patient had never had gonorrhœa. The immediate cause of this epydidymitis seemed to have been a long cold walk with insufficient clothing. Cold applications and a suspensory bandage soon brought relief to his trouble.

It transpired during the course of the

questioning that there occasionally occurred a nocturnal emission which was reddish in color, and that the red color was also sometimes seen after straining at stool, and on one occasion after a cold sea-bath. There was no complaint of a frequent occurrence of these stained discharges, but they had caused the patient some anxiety.

About seven years ago the patient first noticed this discoloration of the semen. There occurred intervals during which there was no staining, and at no time were the losses frequent, occurring on the average once a month. Nothing about the patient or his condition suggested spermatorrhœa.

After the meatus had been snipped, a No. 29 French sound was passed with ease into the bladder, and caused no pain. There was no sensitiveness in the region of the prostate. Rectal examination showed no enlargement or tenderness of the prostate nor of the seminal vesicles. There was no pain on passage of urine or of semen, nor did movements of the bowels cause any distress. The patient had been accustomed to horseback exercise, but it never caused him any distress.

He was requested to bring any specimens which it was possible to save. During the course of several months the following specimens were obtained. Two pieces of cotton cloth stained a reddish-brown, cut from the night-clothes, and a few drops of the fluid which were passed while straining at stool. This fluid was sent to Dr. Gannett, from whom I received the following report :

"March 12, 1886. The small specimen of fluid sent me on the 10th, shows, microscopically, numerous spermatozoa ; a few red blood-corpuscles ; a few granular nuclei ; granules. It certainly deserves the name of a bloody seminal fluid."

The seminal fluid may be discolored in several ways.

An admixture of pus changes its color from gray to white or cream color. An admixture of blood may change the color to a bright red, an orange, a light brown, a dark brown, or a dark red. A dark-blue color¹ is occasionally seen, but its origin is not clearly understood.

The origin of the blood is generally be-

lieved to be in the seminal vesicles. An admixture may take place with blood from an inflamed urethra, but such a case would not be one of true hæmospermatisms. There are several causes for the appearance of the blood.

Vibert² says that slight capillary hemorrhages in the vesiculæ seminales are of frequent occurrence among the continent and among old men. The cause is here an over-distension and irritation of the vesicles.

Many authors (Lallemand, Ricord, Velpeau, Fournier, Gosselin, etc.) speak of bloody seminal fluid occurring after gonorrhœa. An extension of the inflammation to the seminal vesicles is of a rare occurrence.³

Such inflammation is usually unilateral, affecting but one of the vesicles. By the rectum a hard or fluctuating mass can be felt, having the location and the general contour of the vesicle, but larger in size. There is pain on pressure and a constant dull pain which is increased by defecation, by micturition, by coitus, and emission.

Some authors claim that the blood comes from the epididymis or from the testicle, but it seems to be proven that the seminal vesicles are the usual source.⁴

A third cause, generally recognized by all writers upon this subject, is excessive coitus and masturbation. That such excess should lead to congestion and irritation is not surprising.

The character of the patient, and his statements, lead me to believe that the cause of the blood in this case is over-distension of the vesicles. It may be possible that the discharge occurring at times after straining at stool, due probably to the distension of the vesicles and to weakness of the ejaculatory duct, may have resulted from horseback exercise.

The patient has been given fluid extract of ergot, and apparently with good results. The anxiety in the patient's mind has been allayed. He has been told that marriage, instead of being contra-indicated, would probably be followed by a cessation of the symptom.

When we consider the moral effect upon patients of such bloody discharges, it is a little surprising that more has not been written upon the subject in our text-books.

¹ O. Guelliot. *Annales des Maladies des Organes Génito-Urinaires.*

² Nouveau Dict. der Méd. et de Chir.

³ Van Buren and Keyes.

⁴ O. Guelliot. *Annales de Dermat et de Syph.*, 1883, p. 204.

Prognosis and treatment. In the continent and among old men, the condition, hæmospermatis, is of little consequence. Marriage will probably be followed by a disappearance of the symptom in the former. The use of ergot seems to be followed by benefit in this case, and may be tried in all of this class.

In the second class, in which the blood comes from the inflamed vesicles, the symptom is liable to continue as long as the inflammation lasts. Chronic inflammation of the visculæ seminales is of indefinite duration. To cause a disappearance of the symptoms which we are considering, we must cure the inflammatory condition.

In the third class are those cases which result from excessive coitus or masturbation. Here to remove the cause is to effect a cure.—*Boston Med. and Surg. Jour.*, April 14, 1887.

THERAPEUTICS.

Ball (B.) and Jennings (O.) on the Treatment of Morphinomania.—The authors think the most important indication in the treatment of this condition is to tone up the failing heart. To this end they have decided that the best remedy is spartein. They give its sulphate in gr. $\frac{1}{4}$ to $\frac{1}{2}$ doses hypodermically, and repeat it when needed. In a very few minutes the pulse recovers itself, and the malaise disappears. When the symptoms become too alarming, an occasional dose of morphine must be given. The authors have tried nitroglycerine, but do not find it as efficacious.—*La France Méd.*, March 31, 1887.

Josselyn (E. E.) on Twelve Cases of the Morphia Habit.—A comparison of the different methods of treatment demonstrated that about as much disturbance and as many unpleasant symptoms occur when a large amount of the opiate is markedly decreased, or if the regular amount is small and a still further reduction is made, as when the drug is discontinued at once. By immediately withdrawing the drug we accomplish in a few days, with far less suffering and with no more danger to life, what it takes weeks to do if it be gradually reduced.

Of the two cases in which the drug was gradually decreased, one man, and of the remaining ten cases in which it was immediately withdrawn, three men and four

women, so far as could be ascertained, never resumed the habit. The duration of the habit does not seem to bear any relation to the probability of its being resumed after it has been discontinued.

The marked benefit following the use of a bath at as high a temperature as is agreeable to the patient, seems to warrant its more extended use during the excitable period supervening the withdrawal of the drug than has been customary. While in the bath the patient should be carefully observed, and it should be discontinued before any feeling of weakness or prostration occurs.—*Med. Register*, March 26, 1887.

Hare (H. A.) on the Value of the Bile Salts When Used in Conjunction with Inunctions of Cod-Liver Oil.—Within the last few months I have had occasion to use cod-liver oil by inunction several times when the stomach was not in a condition to bear its internal use, and while I have hitherto frequently prescribed this line of medication, I never fully realized the difficulties and the disagreeable conditions produced until such a line of treatment was introduced in my own family. It occurred to me that as one of the functions of the bile salts was to aid the passage of fats through animal membrane, that perhaps they would act in the same manner when applied to the skin, and practical results have proved this theory to be true. In obtaining the salts I have simply gone through the process used commonly in a physiological laboratory, but it may not be out of place to briefly give the method here. To about 300 cc. of ox-gall is added nearly thrice that quantity of ordinary alcohol, and the flask shaken thoroughly. All the mucus is now precipitated and the supernatant fluid is filtered. To the filtrate is added a large excess of sulphuric ether, and after a time a plaster-like mass forms at the bottom of the vessel, which slowly becomes crystalline. These crystals are now placed on a filter paper and washed with a mixture made up of ether and alcohol, equal parts. The filter paper is dried, and the substances then seen are the taurocholate and glycocholate of soda. Having carefully removed these salts from the paper, they are ready for use.

In my experiments I have found that a small pinch of this powder will aid very materially in the speed with which a teaspoonful of the oil is absorbed, and that

the rapidity of absorption is in direct ratio with the quantity of bile salts used. Thus, if half a teaspoonful of the oil be placed on the thin skin of the inside of the thighs, and bile salts added to the oil on one side, both legs being rubbed equally hard, it will be found that the oil with the bile salts added disappears in nearly half the time that is required for the absorption of the pure oil. In addition to the increased rapidity of absorption it will be noticed that even after all the oil has been rubbed in on both legs, there still remains a strong odor of the oil and some greasiness on the limb rubbed with pure oil, while on the opposite limb the odor is greatly decreased, as is also the greasiness, which may indeed be entirely absent, proving that all the oil has passed from the surface.

Several repeated applications of bile salts and oil to the same spot within twenty-four hours has failed to produce any sign of irritation of the cuticle. I think, therefore, that this use of the bile salts deserves more than a mere trial, and the avoidance of the odor and the hand-rubbing is certainly a strong point in its favor, aside from the increased quantity of the oil which is by this means absorbed.—*Boston Med. and Surg. Jour.*, March 24, 1887.

Smith (Q. C.) on the Endermatic Use of Bimuriate of Quinine.—When the use of the cinchona salts is indicated in the treatment of disease in infants and young children, I have found the bimuriate of quinine the most suitable preparation. I prefer to administer it endermatically, and have found the axillary regions the most eligible position for the application of the remedy.

The skin where the medicine is to be applied should be well cleansed just before each application. First wash the surface with warm, soapy water; then with warm water to which a small percentage of ether and chloroform has just been added; then dry well with a soft linen cloth. The following formula is one I often use:

R.—Quinæ bimuriat. gr. xxiv.
Aque dest. f. 3 ss.
M. ft. sol., add Lanolin . . . ʒj.

Mix well.

Sig. Half to one drachm to be applied every two to four hours, in the axillary region, and well rubbed in, as directed.

—*Gaillard's Med. Jour.*, April, 1887.

Schallenberger (H. M.) on a Case of Skin-Coloring from the Continued Use of Nitrate of Silver.—Mrs. I., æt.

forty, who lives in a neighboring town, came to me a few weeks since and said: "Doctor, I wish you would look at my face, and tell me whether you think that there is any probability that this discoloration could be removed by medicine. About two years ago I went to a doctor for treatment to correct a chronic diarrhoea, and he gave me a pill, directing me to take one three times daily, and to continue the medicine for some weeks. I have taken those pills almost every day since that time, never suspecting that this peculiar color of my face and hands was due to the continued use of the medicine. I know the medicine has produced this result, because I called on the doctor the other day, and he told me that I had colored my skin with those pills, and that he did not mean that I should use them for so long a time."

To ascertain the amount of silver she had taken in each pill, I asked for a copy of the prescription, and found the dose had been one third of a grain. This amount, according to her own statement, she had taken almost continuously for about two years. The coloring of the skin is very marked, a dull, dark, metallic appearance in certain lights, and a bright lustre like burnished silver in others. No other case that I have ever seen would, without hearing the history, suggest at once the deposit of silver in the skin as this case does. Then, too, I had seen the lady on several occasions previous to the use of the medicine, and remember her as having had a singularly fair and transparent complexion.—*Med. News*, April 9, 1887.

Anders (J. M.) on the Use of Hydrobromic Acid as a Remedial Agent.—Hydrobromic acid should be employed as an alternate substitute for the bromides in the treatment of diseases in which their effects have been shown to be parallel.

It should probably supersede the alkaline bromides in neurasthenia and post-hemiplegic disturbances of a convulsive character; also (as an arterial sedative) in congestions of the pelvic viscera.

Except when given in colossal doses—a method not practicable in private practice—it appears to be less efficacious than the bromides of sodium and potassium in epilepsy.

Owing to the fact that its action is more evanescent than that of the bromides, it should be administered at intervals of not more than four hours.

The observations by Randolph show the best time for administering it to be after salivary digestion, which is arrested by the acid, is completed, and when free acid begins to be formed in the stomach—about three quarters of an hour after meals. I have given it in doses varying from one half to one drachm at varying intervals. It should, of course, be well diluted, preferably with milk.—*Med. and Surg. Reporter*, April 2, 1887.

Grellety on Cutaneous Lesions Produced by the Bromide of Potassium.—After calling attention to the abuse of the bromides by patients, by druggists, and even by physicians, the author alludes to a case in point where a patient had been taking a concentrated solution of the bromide of potash for about three months.

The patient's hands were eczematous, the extremities swollen, pustular, and bleeding. On the face was an acneiform eruption consisting of large, dark prominences.

The author called attention to the fact that among diabetics a severe furunculosis was apt to be inaugurated by even moderate doses of the drug.

For these cutaneous bromide lesions he advises arsenic, both as a prophylactic and curative agent, while locally he employs poultices, starched bandages, and bathing the parts in a one-per-cent. solution of tannin in glycerine.—*Bull. et Mém. de la Soc. de Thérap.*, Feb. 9, 1887.

Hobbs (M. W.) on a Warm-Ether Inhaler.—My observation convinces me that warm ether is a better, safer, and more agreeable anæsthetic than ether cold, as ordinarily administered.

The administration of warm ether does not cause as much coughing and vomiting as cold ether.

The administration of warm ether is less disturbing to the respiratory system, and does not cause so great secretion of tough mucus in the fauces, as cold ether.

I believe warm ether more stimulating and less inclined to induce congestion of the lungs than cold ether.

I believe patients who are anæsthetized with warm ether suffer less and recover more pleasantly and promptly from it than do those to whom cold ether has been administered.

Doubtless, if warm ether be used as an anæsthetic in case of shock, debility arising from any cause, or for aged persons under-

going tedious surgical operations, there will be less liability to induce or increase already existing bronchial troubles.—*Cin. Lancet and Clinic*, March 12, 1887.

Beyer (H. G.) on the Direct Action of Atropine, Homatropine, Hyoscine, Hyoscyamine, and Daturine on the Heart of the Dog, Terrapin, and Frog.—The conclusions the experimenter arrives at are as follows:

1. Atropine, homatropine, hyoscine, hyoscyamine, and daturine are stimulants of the sympathetic nerve apparatus of the heart.

2. The vasomotor portion of this nerve apparatus is affected by comparatively small doses of these drugs, giving rise to either acceleration or augmentation in the heart's action.

3. The inhibitory portion is excited by larger doses only, giving rise to slowing of the heart's action, and, finally, causing diastolic arrest.

4. The muscular substance of the heart is greatly excited by atropine, homatropine, and daturine, and only slightly so by hyoscine and hyoscyamine.

5. The vasomotor nerves and their ganglia are the first to become exhausted, the inhibitory nerves and their ganglia are the next, and the muscular substance is exhausted last of all.

6. The slowing of the heart's action which follows the administration of these drugs in the intact animal, may be sufficiently accounted for by their influence on the inhibitory nerves and ganglia of the heart itself.

7. The acceleration following the administration of certain doses of these drugs cannot be sufficiently accounted for by their action on the accelerator nerves and ganglia within the heart, but is principally due to causes resident outside this organ.—*Am. Jour. Med. Sci.*, April, 1887.

McLachlan (D. P.) on Atropine and Quinine.—I have lately been administering sulph. atropine in $\frac{1}{16}$ gr. doses to one of my patients in connection with quinine in three-grain doses, and found a remarkable tolerance of the former drug. Having left off the quinine for a few days, I was surprised to find that my patient could no longer tolerate the atropine as before, the symptoms produced being excessive dryness of the throat, dry cough, with difficult deglutition. On resuming the quinine, the toxic effects of the atropine passed off and

she was able to continue the atropine as before. I should like to inquire through your journal if the antagonism between quinine and atropine, as shown by this case, has been observed by other practitioners, or is there some idiosyncrasy in the patient herself to produce it?

I will add that there was no other change in the treatment at the time.—*Med. Age*, March 10, 1887.

Hare (H. A.) on the Physiological Action of Cannabis Indica.—Cannabis indica produces in the lower animals a period of more or less deep sleep, according to the amount of the drug. In both the dog and frog we have a state of heightened reflex action following the dose.

This increased reflex action is replaced by reflex palsy, which is not due to motor-nerve or motor-spinal-tract palsy, but to failure of the sensory side of the cord and nerve-trunks.

The chief action of the drug is upon the centres in the cerebrum; the action on the sensory tract of the spinal cord and nerve-trunks is secondary to its cerebral action.

The only influence exercised on the circulation by the drug consists in a slight slowing of the pulse and a fall of arterial pressure. The slowing is due to direct cardiac depression and not to stimulation of the vagal centres. The fall in arterial pressure seems to depend entirely on the failure of cardiac power.

I desire to call the attention of practitioners to the local anæsthetic action of this curious substance. As already detailed, when applied directly to the nerve-trunks, it paralyzes them, and I have found that when applied to the mucous membrane of the tongue in considerable quantity it diminished sensibility to a considerable degree. Dentists, I am told, constantly use it for sensitive dentine. The drug is too irritating to be used on delicate membranes such as the eye, for I have proved in the dog that it is apt to bring on severe inflammation.—*Théráp. Gaz.*, April 15, 1887.

Chiron (J.) on Camphorated Bisulphide of Carbon in the Treatment of Lumbo-Abdominal Neuralgia.—The remedy consists in a saturated solution of camphor in rectified bisulphide of carbon. It is applied with a brush to the painful region, or is painted upon the skin overlying the lumbar spines or sacrum. A feeling of intense cold follows the applica-

tion, and the skin becomes white from the camphor left behind by the evaporating liquid. Besides its revulsant action, there follows a very remarkable local anæsthesia. The author considers it the best treatment of lumbo-abdominal neuralgia, and he has seen uterine hemorrhages, going with this painful condition, cease after one or two applications.—*Le Moniteur Thérap.*, March 7, 1887.

Martineau on Lithiated Arsenical Water in the Treatment of Diabetes.—This method was first suggested by Rouget. To a quart of seltzer-water he allows four grains of the carbonate of lithia and a tablespoonful of the following solution: arseniate of soda, three and one third grains; distilled water, one pint.

This water should be drunk at meals, and the quart of seltzer thus medicated should last for three meals. If thirsty between meals, the patient should drink the arsenical water solely. The author does not think it necessary to place patients treated in this way on the classical diet, but they must continue to use the remedy one or two years after the sugar has disappeared. He claims to have cured 67 out of 70 patients treated in this way.—*Le Moniteur Thérap.*, April 4, 1887.

Kingsbury (G. C.) on Jambúl Seeds in Diabetes.¹—I lately tried powdered jambúl seeds in a case of diabetes in which the patient had been ill for over six months, was greatly emaciated, and quite prostrate. He was suffering from great thirst and ravenous appetite; there was also great restlessness. The urine had a specific gravity of 1040 to 1042, and from 7 to 7½ quarts were passed in the twenty-four hours. Five grains were given six times in the twenty-four hours for a fortnight. At the end of that period, the patient was able to get up, and walk for an hour at a time, was neither thirsty nor abnormally hungry, and was passing 4 to 5 quarts of urine of a specific gravity of 1020; he could sleep well, and felt strong. During the time he was taking the jambúl his diet was not restricted in any way.—*Brit. Med. Jour.*

Caraman (T.) on the Black Bees of Tasmania and Eucalyptus Honey.—The bees and their honey were discovered by a French explorer, Guilmeth, in 1884. The honey contains a very

¹ See Banatrala, in *Lond. Med. Record*, 1883.

large proportion of sugar (about 612 grammes per kilo.), and several active principles—eucalyptol, eucalyptene, terpene, cymol, resins, odorous and coloring materials (about 170 per kilo.).

The physiological action of this honey has been studied upon animals and man. Some minutes after taking a tablespoonful of the honey in hot water or milk a pleasant sense of warmth invades the entire body. In a half hour elimination of the active principles by the respiratory tract commences, and the voice becomes clearer, the breath perfumed, and the lungs more elastic and supple.

These physiological effects indicate the usefulness of the honey as a restorative, as an antitarrhal sedative of the heart, as a febrifuge, and as an antiseptic and parasiticide. It should be useful in some laryngeal, bronchial, pulmonary, and cardiac affections; in paludian and typhoid fever; in croup and acute catarrh, and in genito-urinary diseases.—*Four. d'Hygiène*, March 10, 1887.

Kesteven (L.) on Eucalyptus in Typhoid.—The author believes that the drug acts as an antiseptic, shortening the duration of the fever by destroying its cause, rendering inert its bacillus; and, secondly, by lessening the severity of the symptoms by its locally acting and acknowledged healing powers. The inflamed and ulcerated Peyerian glands are soothed, and further spread of the mischief arrested.

He has never seen the attendants on cases treated with eucalyptus catch the disease. The duration of the illness till the complete establishment of normal temperature has varied from a maximum of twenty days in one case to the minimum of eight days. The average duration has been about fourteen days.

He has not lost a single case of fever of any kind in nearly two years, and he has had a large number constantly under treatment, all having been typhoid with the exception of a few cases put down as "low fever" for accuracy.

On this he recommends a very thorough trial of the use of eucalyptus in all zymotic diseases.—*Practitioner*, April, 1887.

Péchohier on the Abortion of Typhoid.—The treatment consists in the use of the sulphate of quinine in 15- to 20-grain daily doses and about 3 grains of digitalis per day. Tepid baths lasting 15 to 30

minutes are given three times a day. The author claims to have thus treated 67 cases without a single death, and that the mean duration of the disease did not exceed 14 days.—*Rev. de Thérap.*, March 15, 1887.

Lamb (J.) on Rumex Acetosa in Cancer.—In 1849, directly after I began practising medicine, an old gentleman, a very warm friend, proposed to give me a secret remedy for cancer. The broad-leaved, or horse-sorrel, was to be gathered and prepared at a certain stage of development, bruised in a wedge-wood or glass mortar, the juice expressed out on a pewter plate, dried in the shade to the consistence of honey, then spread on chamois or buck skin, and, after abrading slightly the surface of the diseased part, to be applied daily till the diseased tissue separated from the sound, when the dead mass could be easily removed. After this the best dressing is a weak solution of the medicine in water.

The different species of rumex have the same chemical constituents, and the broad-leaved sorrel not being easily obtained in the locality where I then was, I gathered a quantity of the small-leaved, or sheep-sorrel, at the proper time, to wit: when the bloom began to drop, and bruised it in an iron mortar and expressed the juice out on a common delf-ware plate, and when evaporation had brought it to the proper consistence I put it up in a gallipot. In the first case of epithelioma that came under my care I used it, and was successful. I have used it frequently since, both successfully and unsuccessfully, and I feel safe in saying that the diagnosis, in some, at least, of the successful cases, was correct, as it was confirmed by those high in authority and by the microscope. I think it is fair to admit that it is one of the best and safest escharotics we can use in such cases; and when our patients are not willing to submit to removal by the knife, when the glands are not involved, and the disease has not encroached too much on the underlying tissues, we can safely use this in preference to any other escharotic. Of course the use of any of this class of remedies cannot be compared to immediate removal by surgical procedure.—*Jour. Am. Med. Ass'n*, March 26, 1887.

Rebory on the Use of the Phosphate of Lime in the Sweats of Phthisis.—The author, following Potain, administers the tricalcic phosphate in from

one- to four-drachm doses. He considers it of incontestible utility, and, moreover, has the following qualities which enhance its value. It is not toxic, easy to administer, well borne by the stomach, stimulating to nutrition, remedial to diarrhœal conditions, and can be continued for a long time, not only without inconvenience, but with great benefit to the health of the patient.—*Le Moniteur Thérap.*, March 7, 1887.

Hodgdon (A. L.) on Ergot in Diarrhœa and Sweats of Phthisis.—Seeing an article in one of the Parisian medical journals (*Thérapeutique Contemporaine*, 1886,) pertaining to the value of ergot in the sweats of phthisis, I was led to try it in a case coming under my care. The patient at the time I administered the first dose was in the habit of sweating profusely, and at the same time was troubled with a phthisical diarrhœa. The ergot was given, but the administration of it at first, in the dose of thirty drops of the fluid extract thirty minutes before the general advent of the sweating, seemed to have but little effect, in the way of stopping the sweats, but the drug acted as if by magic on the diarrhœa, causing almost a total cessation of the same, and the diarrhœa having started again, the patient was placed upon twenty drops of the fluid extract of ergot three times in twenty-four hours; this relieved it somewhat, and at the same time ameliorated the exhausting sweats. I have given with advantage agaricine and belladonna (in ordinary doses, in pill form together) for the purpose of alleviating exhausting colliquative sweats; but if in ergot we are able to find a remedy that can for a period be given in place of (that extremely disagreeable drug, its physiological action) belladonna, and if we can find in it a drug which can for a time be substituted for opium for the purpose of controlling the diarrhœa, to which many of the phthisical are subject; if in ergot we find these advantages, before mentioned, then we will be able to afford to the phthisical, slight intervals of rest from the use of opium, and (its physiological antagonist) belladonna.—*Maryland Med. Jour.*, March 26, 1887.

Sperry (S. B.) on Abortion Following the Use of Permanganate of Potassium.—I was called February 25th to see Mrs. B., aged about thirty-five. She said at her last menstrual period she had

flowed only two days, and since then had not felt her usual self. It was time for her to be unwell again. A day before she got wet. She was positive she was not pregnant. She suffered with intense headache, backache, and soreness, slight elevation of temperature, and vomiting.

I gave her morphine for the headache and aconite, not having any permanganate with me. The next day she was somewhat better, and I then left her eight 2-grain capsules of permanganate of potassium, one to be taken three times a day. The first one she vomited, the second and others were retained with difficulty and only by drinking freely of water.

The next day she began to flow, and flowed freely that night. I saw her the next day.

The cervix uteri was well dilated and something protruding, which was thoroughly removed, and found to be a fœtus a month old. Recovery good.—*Thérap. Gaz.*, April 15, 1887.

Scott (J. Z.) on Chloral Hydrate in Labor.—For a great many years I have been using hydrate of chloral in cases of labor, with remarkable results. When I am called to attend a woman in labor and find the os undilated or rigid I invariably inject into the rectum 30 grains of hydrate of chloral dissolved in about four ounces of warm water, with a little starch added. I have used this means for such cases for eight years, and have failed to get any but the most flattering results—in fact I cannot praise the method too highly. On the 28th of this month I was called to a case of placenta previa; the woman had been flowing all night, and when I got there, at 6 o'clock, A.M., she had lost much blood. I found the os rigid and undilated. I immediately injected my favorite remedy, and in less than three minutes the os was dilated so that I could readily pass my hand into the uterus, and it relaxed also the rectum, vagina, and perineum. The drug never failed me yet in this connection, and I would like to commend it to others who may not have used it.

I have had excellent results with it, also, in cases of dysentery. Injected into the rectum, it will surely relieve tenesmus, either of rectum or urethra.

I do not claim to be the originator of this method of using chloral in labor, having seen an article on the subject in the *Therapeutic Gazette*, I think nine or

ten years ago. I have forgotten who wrote it, but the author recommended it for dilatation of the os. I tried it then and found it all he said, and have used it always since.—*Med. Age*, April 11, 1887.

Colrat on the Treatment of Warts by the Internal Use of Magnesia.—The author does not attempt to explain this action of magnesia, still he asserts that he has repeatedly seen warts disappear from children while taking two- or three-grain doses of the drug twice a day. Very large but non-polypoid warts the author has seen disappear under this treatment. Aubert reports the case of a woman whose face was covered with warts, but not her hands. He gave her a drachm and a half of the sulphate of magnesium daily and, after a fresh crop of warts had come out, they all disappeared in a month and a half. Roux reports a case where large and numerous warts disappeared in fifteen days after the administration of ten grains of the drug daily.—*Rev. de Thérap.*, April 1, 1887.

Ergot in Erysipelas.—One of the most unsatisfactory processes to deal with, on account of the want of success attending our efforts, is that of rapidly spreading erysipelatos inflammation. A local application which is never mentioned in text-books or papers, at least it has escaped our notice if it is, but which has proved to be of the greatest practical value in one of the large institutions of this city, is the fluid extract of ergot. This remedy, which answers all theoretical as well as practical purposes, has been found to far surpass all other local remedies in the treatment of this affection in this institution, at which we had an opportunity of seeing it constantly used for a year in a ward, set apart for those cases, which was never vacant. It is painted on with a brush quite thickly, and rapidly dries, protecting the skin from the air, and beside, answering the theoretical purpose of contracting the gorged capillaries. Success with this procedure was so pronounced and uniform, that nothing was ever used in its place, the case being treated with the full confidence in its powers to allay the pathological process gained by repeated successes.—(Edit.) *Weekly Med. Rev.*, April 9, 1887.

Mairet and Combemale on the Toxic Action of Colchicine.—The minimum toxic dose in cats and dogs is,

hypodermically, $\frac{1}{10}$ grain; by the mouth, $\frac{1}{20}$ grain. Given in the former way, it is more rapidly toxic. Its action as an irritant poison is upon all organs, but pre-eminently upon the alimentary canal and kidneys.

The drug is eliminated in various ways, but particularly in the urine, but this elimination is so slow that the non-toxic doses may cause death in five days. Colchicine produces congestion of the articular extremities and marrow of the bones.—*Rev. de Thérap.*, March 15, 1887.

ORTHOPEDIC SURGERY.

ABSTRACTS AND SELECTIONS BY JOHN RIDLON, M.D.

Bradford (E. H.) on the Treatment of Lateral Curvature.—The principles of treatment of any disease depend largely upon the theory of causation. This is particularly true of lateral curvature. Although many other theories have been advanced, it may be accepted as more than probable that the distortion is the result of superincumbent weight pressing upon a weakened spinal column, held in a position out of the vertical line.

The treatment of lateral curvature should vary according to circumstances of the case, and largely according to the stage and degree of the affection. It is manifestly as irrational to incase in a stiff corset, certain to produce muscular atrophy, a trunk dropping to one side from a want of muscular development, as to attempt to correct a fixed curve with osseous change by muscular exercise. Cases should be treated according to the indications. Bearing in mind the factors which cause the distortion, the aim of treatment should be:

- 1st. To remove the superincumbent weight.

- 2d. To develop the strength of the structure of the spinal column.

- 3d. To keep the spine as far as possible from deviating from the vertical line.

The two means of accomplishing the first are recumbency and suspension, and they can only be employed as adjuncts. A great deal, however, can be done towards maintaining a proper position of the spinal column, and it is in this direction that the chief efforts in the treatment should be directed.

There are three methods worthy of consideration, namely :

- The postural,
- The gymnastic, and
- The mechanical.

The postural treatment is that method where correction is sought by instruction in proper attitude.

The following are the exercises which Mr. Bernard Roth, of London, prescribes, varying in a measure in individual cases :

1. Lying on the back, arms by the side, hands supinated, very slowly, deep inspirations by the nose, expirations by the mouth.

2. The same, with arms extended above the head.

3. Position the same as No. 1, head rotation, lateral flexion of head.

4. Position the same, simultaneous circumduction of both shoulder-joints from before backwards, elbows and wrists extended.

5. Position the same, one hip circumducted both ways (knee extended).

6. Lying on back, simultaneous extension of both arms upwards, outwards, downwards, from a position of the elbows flexed and close to the trunk.

7. Lying prone, one hip circumducted both ways, knee kept extended.

8. Sitting on a couch, with back at an angle of 45° , ankle circumducted in, up, and out, while the toes are inward the whole time.

9. Lying on back, with arms extended upwards by the sides of the head, flexion of both arms (surgeon resisting). (The patient's knees, flexed over the ends of the table, fix the trunk.)

10. Patient astride a narrow table, with arms down and hands supinated, trunk-flexion of lumbar vertebræ (patient resisting), followed by trunk extension (surgeon resisting).

11. Patient, with arms extended upwards, leans against a vertical post with pegs on each side ; these he grasps. The surgeon gently pulls the patient's pelvis forward by his hands on the sacrum (patient resisting), also pelvis rotation on its axis to right and left alternately (surgeon resisting), with the hands on each side of the pelvis.

12. Lying on back, with head and neck projecting beyond the end of the table, the head is gently flexed by the surgeon's hand on occiput (patient resisting).

In addition to those already mentioned, the following will be found of use :

1. The patient sits facing the assistant, who holds a strap passing about the patient's occiput (prevented from slipping by a cross strap around head and chin). The patient bends forward and back, keeping the spine straight. The backward movement is resisted by the assistant.

2. The same as above, except the strap crosses the shoulders.

3. The patient stands facing a wall at arm's length from it ; places the left hand upon the wall, at the height of the chin, the hand being in a direction across the body. The patient, supported by the arm, slowly brings the face towards the arm, bending at the ankles, keeping the whole body in line ; the face should be turned so that the left ear touches the hand, and the standing position slowly resumed, the body being still kept from bending at the hips.

4. The patient stands with the heels, back, and occiput against a projecting corner (of furniture or doorway), and places the elbow (the arm being flexed) as far back as possible.

5. The patient, seated on a stool or chair, should place the feet behind and on the inner side of the front legs of the chair and slowly bend sideways ; the assistant, resisting on the head, determines the strain on the muscles of either side.

In almost all flexible cases, and in a majority of cases with commencing osseous curves, all the treatment that is required is postnasal and gymnastic thoroughly carried out. In certain cases of this class, and in most of the severer cases, treatment by some mechanical aid is needed. It should, however always be borne in mind that mechanical supports are injurious in so far as they take the place of muscular support, and therefore defeat the object to be arrived at in an ultimate cure. They should never be used to the exclusion of gymnastics. In cases of pronounced fixed curves with marked changes in the bones, when the curves do not diminish when the patient is recumbent or suspended, and rotation is indicated by projection of the ribs when the patient bends forward, a cure that is a complete correction of the deformity is not to be hoped for.—*Boston Med. and Surg. Jour.*, Sept. 9, 1886.

Gibney (V. P.) on Lateral Curvature of the Spine.—The etiology is obscure. It is almost as obscure as that of

club-foot. It is usually observed between the ages of eight and fourteen years ; and in boys and girls who work in shops, or in school children who habitually assume a vicious position in sitting or standing. Downward pressure is an important element in the production of lateral curvature.

A marked case of this kind I now show you. In the lower and middle dorsal region there is a curvature, the convexity of which is towards the right, and on that side the ribs stand out sharply, while on the opposite side they are flattened. There is also a projection of the right scapula ; it is raised on a higher plane than the other ; on the concave side the inferior angle of the scapula stands out farther from the ribs. Suspension shows more plainly the degree of the deformity. Another point is the atrophy of the right mamma, and this is a very constant and very persistent symptom of lateral curvature in the female.

With regard to the treatment, if the patient is seen in the early stages of the disease, before there is much deformity, it will be well to treat the case for a while by gymnastic exercises. If after two or three months there is no change in the deformity, or if it has increased, no time should be lost in the employment of an apparatus. The apparatus is not intended to correct the deformity, but to prevent further deformity. Self-suspension will bring the spine into a straight line, and then any apparatus that will hold it so, whether made of steel, felt, or other material, will be a good brace. I am in the habit of using the plaster-of-Paris corset, for the reason that I renew it every two or three months. The child having exercises all the time, I expect to get an improvement in position every time I renew the jacket. It is taken off sometime before going to bed, kept off during the night and for some time in the morning.—*Med. Times*, Dec. 25, 1886.

Andrews (E.) on the Incision, Digital Exploration, and Drainage of Lumbar Abscess.—Lumbar abscesses, in their own intrinsic nature, are no more dangerous than others. They are rendered especially perilous only by the inefficiency of our explorations, and by consequent incompleteness of our local treatment. When thoroughly explored and kept completely disinfected, they rarely cause death. I

grant that certain cases are best treated at the outset by repeated aspiration, but if this fails, or is inapplicable from the abscess being already open, then the open method with regular disinfection is necessary.

Assuming this to be true, the thorough exploration of the interior of the abscess is a prime necessity, and it cannot be accomplished without the use of the surgeon's finger. The time to be selected is the earliest one at which a diagnosis can be made.

The first step in the operation is to open the external sac widely. The second is to examine the floor of the cavity until we find an opening leading to the inner sac. Dilating this orifice, with the aid of an incision, if necessary, the finger is inserted to examine the interior. The spinal column can be examined to search for necrosed portions, or for excavations whence sequestra have previously exfoliated. In the lower parts of the sac pieces of the exfoliated bone are sometimes found. Every opening must be tubed, and the cavities all be kept well disinfected.

Nine cases are recorded. In four the abscess was due to Pott's disease, and in the remaining five the cause of the abscess was not clearly made out. All, except one, of the second class, who died of septicæmia, did well up to last reports, but none were followed to ultimate results.—*Four. Amer. Med. Ass'n*, Oct. 23, 1886.

Althaus (J.) on Some Points in the Pathology and Treatment of Paraplegia Dependent on Pott's Disease.—The case reported was placed on the iodide of potassium and cod-liver oil, with complete rest and frictions with liniments, etc., but at the end of three months no improvement whatever was noted. Applications of the actual cautery were then made to the side of the spine. Within a few days the patient was perceptibly better, and within a short time she could walk as well as ever, and the coldness, lividity, and perspiration about the ankle disappeared. It could not be doubted that the powerful counter-irritation resorted to in this instance had brought about a cure by its effect on the diseased structures involved.—*Boston Med. and Surg. Jour.*, Oct. 28, 1886.

Lewis (M. J.) on Infantile Palsy. Infantile paralysis very frequently develops in the month of August, after the hot

weather in July. A child, apparently well, may be taken with convulsions, vomiting, diarrhoea, or high fever. There is pain on motion. The convulsions may pass into coma. Upon recovery from the attack, which may require from half a day to a week, the child is found to be more or less paralyzed, usually in one leg, sometimes in both. The arms may also be affected. As a rule, the paralysis involves the anterior muscles of the leg. There is no diminution of sensation. Very soon the paralyzed muscles begin to waste, the bones also fail to develop, the temperature of the affected limb is lower than that of the opposite side.

The diagnosis of this affection in the early stage is not readily made, and the treatment must be purely symptomatic. Usually the diagnosis is readily made after the paralysis has appeared. The face is rarely affected in infantile palsy. In paralysis resulting from apoplexy there is not this coldness of the skin, and the degeneration reactions are wanting. In cases of brain disease, there is usually secondary sclerosis of the spinal cord, and, as a result there is a great increase in the knee-jerk. In infantile palsy the knee-jerk is not altered, unless the thigh muscles are affected, when it will be lost.

The treatment in these cases consists largely of good nursing and proper care. The most important thing is to increase the nutrition of the paralyzed muscles by massage and electricity. The internal treatment should be of a tonic, supporting character, consisting of strychnia, iron, and cod-liver oil, after the acute stage has passed.—*Arch. Pediatrics*, Oct., 1886.

Wheelhouse (C. G.) on Deformities of the Skeleton, and their Treatment by General and Surgical Means.—To my mind, every thing appears to point with greater probability to syphilis as the fundamental and basic poison of rickets, aided and developed by an environment which, while insufficient to originate the disease, was efficient to light up the fire of which syphilis had previously laid the materials.

I do not propose to enter at any great length into the details of the constitutional treatment by which we endeavor to mitigate the evils of approaching or apprehended rickets. Fortunately, the oncoming of the disease is heralded by unmistakable signals; and, long years ago, Sir William

Jumer pointed, with unerring certainty, to the signs of its approach: (1) tenderness of the general frame, which makes the child shrink from playfulness and the romping so generally loved by children; (2) the child's exceeding quietude and "goodness" so long as it is left motionless and undisturbed; (3) its determined efforts to kick away its bedclothes, and to lie naked at night; (4) the profuseness with which, notwithstanding such nakedness, it sweats, especially about the head, whenever it sleeps; (5) the precariousness with which it sleeps, and the uncertainty with which it feeds. Then, next, there come into prominence the disproportion between the cranium and the face, the prominent protuberant forehead, the enlarged and thickened joints, especially the wrists and ankles; and, finally, the general distortion of the bones, the ill-formed chest, the flattened pelvis, the twisted and bent limbs, the weakened and yielding joints; and so the disease becomes established.

Now, if I have been correct in my estimate of the causes by which this condition has been brought about, the general line of its constitutional treatment must be clear and well defined. A healthy home, sunlight in abundance, fresh air in unlimited supply; warm, porous, and light clothing; carefully chosen and nutritious food; and a tonic and anti-sphyilitic line of medication, with iodide of potassium as the salt of life; and iron, in some form, as the aid of the staff of life; and mild and occasional mercurials as the scavengers of the blood and *prima via*, will effect all that the physician can do.

It was a day of rejoicing with me when I was able to supersede it (Ogston's operation) by the more efficacious and unquestionably less dangerous method proposed by Dr. MacEwen, of simply dividing the shaft of the femur above the joint, and without the risk of interfering with it.—*Brit. Med. Four.*, May 22, 1886.

Rigby (J. A.) on Mollities Ossium in the Male, with Spontaneous Fractures.—Mollities ossium, in the male, is extremely rare. This case was typical of the disease as usually seen in women after repeated pregnancies. William G., aged forty-three, married, a schoolmaster, with no family history of any softening of the bones, about eight years ago began to suffer from severe pains in the knees, attributed to rheumatism. Then followed

pains in the feet, shoulders, and hips; dislocation at right hip; loss of muscular tissue of the hands; marked shortening of the unequal phalanges; and all the other phalanges were enlarged at their bases. There was bulging of the chest and swellings at the junction of the ribs with the costal cartilages. There followed fracture of the right humerus and right femur. There was no change of the bones of the head; no cough, diarrhoea, perspirations; no pyrexia or hectic. The mental faculties were perfect.—*Brit. Med. Jour.*, July 3, 1886.

Robson (A. W. M.) on a Case of Separation of the Upper Epiphysis of the Left Femur.—The case is believed to be either a separation of the epiphysis or a fracture through the neck of the femur. The patient, aged five years, was let fall, four years previously, striking heavily on the left hip. The signs on admission were: Marked limp on walking, the patient leaning to the left; well-marked eversion of the foot, which could, however, be brought parallel with the right without giving pain; ability to completely flex and extend the thigh. Measured from the anterior superior spine of the ilium showed three quarters of an inch shortening; measured from the great trochanter there was no shortening. By Nélaton's and Bryant's line the great trochanter was raised three quarters of an inch.—*Lond. Lancet*, Aug. 21, 1886.

Whitehead (W. R.) on Some Recent Cases of Hip-Joint Disease, Including Two Cases of Excision, and One of Brisement Forcé, with Remarks on Some Others.—(1) Case of hip-disease of over three years' duration. There was pain, limited motion, and abscess in front at the time of the excision. (From the engraving, Fig. 1, there also seems to be flexion, adduction, and rotation outward.) Four and one eighth inches of the upper end of the femur was excised, and considerable dead bone removed by the bone gouge from the acetabulum. The dressing was with balsam of Peru and oakum, and the patient put in a wire cuirass. During the treatment, while making forcible flexion at the knee, the tibia was broken at the upper epiphyseal line.

Six months after the operation he has less than an inch shortening, wearing a shoe with slightly raised sole, and has, I may say, perfect motion at the hip-joint.

There still remains a slight superficial sinus at the site of one of the lower drainage-tubes. [The engravings, Figs. 3, 4, 5, seem to show more than an inch shortening, slight abduction, some flexion, and lack of normal extension.]

(2) Hip-disease of less than three months' duration, with abscess and rapid and extensive destruction of the bone; death on the ninth day from rapid blood-poisoning. The condition of the patient was very bad before the operation. Two and a half inches of diseased femur was removed and the acetabulum scraped out. The dressing was the same as in the previous case.

(3) Fibrous ankyloses, following hip-disease of three years' duration; tenotomy; brisement forcé; restoration of perfect motion, with only one and one eighth inch shortening. The patient had been treated by Hutchinson's method. There was three and a half to four inches shortening. The adductor longus, gracilis, and rectus femoris muscles were cut subcutaneously. Then the adhesions were broken up and free motion obtained. The patient was put in a wire cuirass. Passive motion was commenced at the end of two weeks. Perfect motion was obtained and freedom from all pain. A modification of the Sayre and Shaffer splints was applied, more as a support to the limb than as an extension apparatus.—*Med. Record*, Dec. 18, 1886.

Taylor (L.) on Morbus Coxarius.—Specimen exhibited at meeting of Academy of Medicine, Cincinnati, January 17, 1887. The patient was three months old at the time of death. First symptoms were noticed when a month old. Abscess formed, and was aspirated two weeks later, when spontaneous dislocation of the head of the femur on the dorsum of the ilium was found. The child went on through the stage of progressive atrophy until it died, six weeks later, without any reaccumulation of pus in the joint, and without apparently suffering pain. The cause of the disease cannot be determined. The great majority of cases in infancy are certainly due to syphilis, but the patient has shown no evidence of it except in the mal-nutrition and atrophy.—*Cin. Lancet-Clinic*.

Morrow (S. R.) Report of Five Cases of Knock-Knee Treated by MacEwen's Method.—There may be three theories to account for the production of genu valgum, viz.: the ligamentous, the muscular, and the osseous. It is be-

lieved that section of the external lateral ligaments cannot cure the deformity. In some cases the biceps muscle is found contracted, together with the fascia, but this is a secondary, not a primary, condition. The osseous change may be an increased growth of the internal condyle; an atrophy of the external condyle; an overgrowth of the diaphysis on the inner side; simple rachitic binding of the lower end of the femur; the inner articulating facet of the tibia being on a higher plane than the outer; or, finally, the deformity may be due to any combination of these conditions.

For pronounced cases, like those reported, treatment by supports or braces is wholly inadequate. Nothing will answer but some form of operation upon the bones, and all operations aim to cut the bones subcutaneously.

The indications for correction of the deformity are to make the section of the femur so as to keep well above the epiphyseal line and outside of the knee-joint, and the simplest method of accomplishing these results is to be chosen. The operation known as MacEwen's supracondyloid osteotomy seems to fulfil all these requirements, and it is the operation I performed.

The points given by MacEwen for the proper performance of the operation are these: With the limb extended, ascertain the upper margin of the external condyle, and measure a finger's breadth above the same, and draw a line from this point across the front of the limb, this line to be at right angles to the long axis of the femur, and not parallel to the articulating surface of the condyles. Now draw a line along the inner aspect of the limb parallel to its long axis and about half an inch in front of the tendinous insertion of the adductor magnus muscle. At the point where these two lines intersect the incision is to be made.—*Albany Med. Annals*, July, 1886.

Allingham (H.) on Congenital Lateral Displacement of the Patella.—Mr. Allingham showed two cases of what he described as a rare occurrence, namely, displacement of the patella outwards. The quadriceps muscle was atrophied; on extending the leg, the vastus externus was seen to be large, but the internus was flabby and small, and it did not seem to act. There were two theories put forward to account for this condition: first, that the internal lateral ligament was lax; and

secondly, that there was paralysis of the quadriceps.—*Brit. Med. Jour.*, Dec. 4, 1886.

Parker (R. W.) on Congenital Club-Foot; the Part Played by the Tarsal Ligaments in Maintaining the Deformity; and the Value of Their Subcutaneous Section in Its Cure.—The only constant condition found [on dissection] was the inability to overcome the deformity (even after the removal of all the muscles), until some of the ankle and tarsal ligaments had been divided. These ligaments are short, but they are not shortened; they are as they have been developed; they are in the same condition as certain of the muscles—that is to say, shorter than normal, owing to the fact that the points of attachment have been unduly approximated during development and growth. Microscopic examination of the muscles shows them to be histologically normal in all respects in early infancy; the nerve trunks also, and the spinal cord, show a healthy structure; the full supply of normal ganglionic cells was particularly striking in the lumbar enlargement in the cases examined. All the constituent bones are slightly altered in shape; they present, when seen in horizontal section, a slight incurvation; in severe cases this may be very accentuated. The importance of taking cases of congenital club-foot in hand very early, before ossification of the bones has occurred, or had time to complete itself, becomes abundantly manifest.

As regards the ligaments, structurally I have not found any changes at all. The condition, which was abnormal in them, is purely anatomical and consists in an altered and abnormal mode of attachment. The ligaments chiefly at fault are those placed on the inner border of the deformed foot, namely, the anterior portion of the internal lateral ligament of the ankle, the astragalo-scapoid, and the calcaneo-scapoid, all three being blended together into one indistinguishable capsule of great strength; in a less degree, the capsular ligaments between the scaphoid and the internal cuneiform bone and between the latter and the first metatarsal bone are at fault. In the severest cases, in which the patient walks on the dorsum pedis, the long and short plantar ligaments will be found short. Hence it follows that tenotomy leaves the major part of the anatomical conditions unaltered. With the exception of the calf

muscles, as represented by the tendo Achillis, I believe, in the majority of cases, the leg muscles may be elongated to the required extent by systematic manipulation. The ligaments are so extremely short that we cannot expect much gain from stretching them. Therefore I would urge the subcutaneous division of the tarsal ligaments.

The tenotomes used are very small; the blade being less than an eighth of an inch broad and half an inch long. The sharp tenotome is spear-shaped, with cutting-edge on either side; and in addition to the ordinary-shaped, blunt tenotome there is a curved one with the cutting-edge on the concave. The patient is usually anesthetized and an Esmarch's bandage applied. The curved tenotome is entered immediately in front of the anterior border of the internal malleolus, the blade, as far as possible, being kept between the ligaments to be divided and the superjacent skin. The blade is then turned towards the ligament and it is divided; keeping the knife close to the bones, the other bands are then divided. The deformity is at once rectified and the foot put up in a plaster-of-Paris bandage. This first dressing is usually left on for a week to a fortnight; then manipulation, etc., may commence.—*British Med. Jour.*, July 3, 1886.

Churchill (F.) on the Multiple Causation and the Immediate Treatment of Congenital Club-Foot.—By multiple causation I shall endeavor to show that not one tissue more than another—that is, to the exclusion of another—is involved as the developmental cause of this deformity. Tendons, ligaments, fasciæ, and bones each become subject to the contractile force of the involved muscles in their relative proportions.

By immediate treatment, I mean forcible and powerful extension, and manipulation of bones, ligaments, and fibrous tissues immediately after dividing the faulty tendons.

When infants are brought sufficiently early—that is, during the first twelve months—I consider that manipulation and extension are all that is necessary to rectify the deformity after tenotomy. It is only in extremely rigid cases that division of the ligaments is required.

After dividing faulty tendons, I proceed to manipulate the astragalus and other misplaced bones, so as to stretch the liga-

ments and replace the foot in its normal position. A firm but elastic roller of Welsh flannel is applied to the foot and leg in two or three layers. Stretching the bandage slightly, I make the turns so that they may grip the soft, fleshy, elastic limb of the infant. Round the foot part I place a circlet of webbing to protect the sole, and to give additional leverage power to the extension apparatus, which may be fastened to the webbing. I then select a piece of perforated tin, of the proper width—that is, from half an inch to an inch, according to the age of the child—having jagged perforations alternately on the inner and the outer side. I then shape the strip of tin so as to traverse the sole of the foot-level with the metatarso-phalangeal joints. I bind it to a sharp right angle on the edge of the table, so that the vertical portion of the tin shall pass up level with the fibula, and be pressed against the flannel covering the leg. The muslin bandage, charged with plaster-of-Paris in the usual way, should then be applied as a spica from the toes upwards, each turn being made so as to raise and evert the foot, and secure a purchase over the outer side of the perforated tin. This rectangular tin lever is embedded between layers of muslin and flannel.—*British Med. Jour.*, Nov. 27, 1886.

Allingham (H.) on a Remarkable Case of Pes Gigas.—The hypertrophy appeared to affect only the anterior part of the foot, and involved the cellular tissue chiefly. The bones did not appear to be enlarged. There was no evidence of nevoid tissue in the hypertrophy, which probably involved the lymphatic and connective tissues. Mr. Davies-Colley had recorded a somewhat similar case in the *Pathological Transactions* some three years ago. The foot was amputated through the metatarsal bones. Billroth has pictured such cases in his "*Clinical Surgery*." Mr. W. H. Bennett had treated a case of the kind by partial amputation, with very good result. There was some tissue that resembled myxoma.—*Lond. Lancet*, Dec. 4, 1886.

Sayre (L. H.) on the Necessity of Recognizing "Reflex Spasm" Produced by "Point Pressure" in Contractured Tissues, and of Making Proper Division of the Same before any Mechanical Treatment can be Effected.—Deformities are usually classified under two heads—congenital and acquired. These two classes are subdivided

into (1) deformities due to paralysis, and (2) into those due to contraction or shortening of certain tissues.

Contracted tissues may be divided into (1) *contracted*, and (2) *contractured*.

A *contracted* tissue is one which is simply shortened and impaired in its movements, and which can be restored to its normal condition and length by simple stretching and manipulations.

A *contractured* tissue is one where the parts forming the tissue have become changed in their anatomical structure to each other, and cannot be lengthened except by a severance of the resisting tissues.

When a contracted tissue is put upon the stretch and then additional pressure is made upon the tissue, no pain or voluntary spasm is caused. If, on the contrary, this additional, or "point pressure," upon an already stretched tissue causes pain and an involuntary contraction, or spasm of the muscles of the entire body, the tissue thus stretched has become *contractured* or changed in its structure, and must be severed before the parts can be brought into their normal relations.

To attempt to stretch a *contractured* tissue is to subject the patient to a great amount of unnecessary pain, and at the same time run the chance of producing serious disturbance of the nervous system.

After division of the contractured tissues and union between the divided ends has taken place, massage, frictions, active and passive motions, with the use of electricity to develop the weakened muscles, together with such mechanical appliances as may be required in each case, will be demanded, and must be thoroughly practised for many months before the cure is complete.—*Virginia Med. Monthly*, Oct., 1886.

Sayre (L. A.) on the Necessity of Cutting Contractured Tissues in Cases of Deformity, before Traction is Attempted.—The same laws are laid down as above (Sayre, L. H., etc.) regarding *contracted* and *contractured* tissues, and two cases are related.

The first, in a patient six years old, of double, congenital equino-varus, which had been treated for twelve months, by a prominent orthopædic surgeon of this city, with a shoe of his own construction, applied for a few minutes to each foot daily, which was capable of making very powerful traction upon the contractured parts.

The plantar fascia, tibialis anticus,

and tendo Achillis of either side were divided subcutaneously, and the feet *immediately* restored to the normal position. In three weeks he walked very well with both heels on the floor in an ordinary shoe.

The second case was a patient nine years old. The deformity was equinovarus following convulsions when eleven months old. Tenotomy had been performed when twenty-four months, but without satisfactory result. A year ago he had been stretched with an "extension shoe," the same as that used in the previous case, daily for three months. Pressure on the contractured tissues caused reflex spasm. The treatment and the result was the same as in the first case.—*New Eng. Med. Monthly*, Nov. 15, 1886.

DISEASES OF THE NOSE AND THROAT.

ABSTRACTS AND SELECTIONS BY C. H. KNIGHT, M.D.

A Case of Foreign Body in the Nose and Antrum.—At a meeting of the Section in Laryngology and Rhinology of the New York Academy of Medicine, Dr. T. O. Vanderpoel showed a zinc plate, over two inches long by an inch in width, removed from the posterior nares by means of forceps. The foreign body was a piece of firework which had been driven into the left cheek and firmly lodged in the antrum by a premature explosion. The original wound was closed with sutures, after removal of pieces of paper, etc., and slowly healed. In the course of several months the patient began to complain of hemi-crania, trouble with the eye, impaired voice, and general poor health. At the same time large quantities of pus were discharged from the posterior nares. The left nostril was found to be occluded, and the foreign body was detected with a probe. It could not be dislodged; the patient was etherized, and the original wound was opened, but still the metal remained firmly impacted. Finally, the soft palate was divided in the middle line, and after manipulations lasting nearly two hours the body was removed.—*N. Y. Med. Jour.*, April 16, 1887.

A Foreign Body in the Nasal Cavity.—Dr. J. A. Stucky reports a case in which he removed a hair-pin, two inches long, from the posterior nares, by means of

post-nasal forceps. The foreign body had been in the right nasal fossa for five months. It lay with its curved extremity posteriorly. It was so firmly impacted, and so concealed by swelling of the soft parts and by adhesions, that its detection and removal seem to have been attended by considerable difficulty.—*Am. Practitioner and News*, March, 1887.

On the Nature and Treatment of Hypertrophies and Tumors of the Nasal and Pharyngeal Cavities.—In a paper read by Dr. Thudichum before the West London Med.-Chir. Society the author mentioned that he had for many years maintained the theory of nasal-reflex neuroses. He believes in a combination of operative and general treatment, and that the former will not alone accomplish a fundamental cure. The use of the term "erectile," as applied to nasal tissue, is objected to. The great advantage of the electro-cautery, and of cocaine over general anæsthesia, is insisted upon.—*The Medical Press*, Feb. 23, 1887.

A Novel System of Operating for the Correction of the Deflected Septum by Means of an Electric Motor, Nasal Drills, and an Original Spray-Producing Device, with Illustrative Cases.—At a meeting of the Laryngological Section of the New York Academy of Medicine Dr. W. C. Jarvis exhibited what is known as the "C. & C." electric motor, capable of performing 2,000 revolutions per minute, and said to possess capacity equal to one eighth horse power. He also showed what he calls a "rasp drill" and a "nasal plane," instruments which are found useful for removing bone and cartilage without injuring the mucous membrane. The point of the drill may be kept in view by using a right-angled gearing device adjusted to the hand-piece. The field of operation may be kept clear, moreover, by the use of a spray-producing device, or air-douche, which has been designed by the author. These instruments, together with Dr. Holbrook Curtis's "nasal trephine," are valuable additions to the armamentarium of rhinologists.—*N. Y. Med. Record*, April 9, 1887.

Epileptiform Seizures from Post-Nasal Polypus.—In the *Asclepiad*, No. 13, 1887, Dr. B. W. Richardson reports an example of this rare nasal reflex. A large gelatinous polyp, the size of a walnut, was removed with forceps. The growth had

not returned and there had been no epileptiform seizures for eight years.—*Am. Jour. Med. Sci.*, April, 1887.

Nasal Reflexes as a Cause of Diseases of the Eye.—Dr. W. Cheatham reports several cases in illustration of the relation between diseases of the eye and the presence of polypi in the nasal fossæ, and expresses the belief that many cases of asthenopia have their cause in the nose, especially in its anterior part.—*Am. Practitioner and News*, April 2, 1887.

Removal of the Tongue by the Galvanic Ecraseur.—Mr. T. Kilner Clarke, in the *Provincial Med. Jour.*, March 1, 1887, claims to have performed some years since an operation for the removal of the tongue very similar to one described by Dr. F. A. Purcell in the *Lancet* of Sept. 18, 1886. The essential features of the operation are first, division of the attachments of the tongue to the mouth, the tongue having been transfixed laterally near the base. A curved trocar is then passed from the suprahypoid region into the mouth, just in front of the epiglottis. Through the canula the platinum loop is drawn forward over the tip of the tongue and pushed back to its base. It only remains to tighten the loop and connect the battery.

There is one point of great practical importance in connection with the operation, and that is not to have too strong a current from the battery. The weaker the current compatible with cutting through the tissues, the less likelihood there is of hemorrhage. As a rule, it is quite sufficient if the wire is kept at a dull red heat. And again, it is important to have wire not too thin, or it may break, as it twice did during an operation at which I lately assisted. I would suggest wire about one mm. thick.

The operation described is equally suitable for the removal of half or part of the tongue. In such a case the first step is to pass a curved needle, armed with the platinum wire, through the raphe, the attachments of the tongue and the tongue itself, bringing out the needle-point just in front of the epiglottis. The needle is then withdrawn, leaving the loop of wire, the ends of which are attached to the battery. The tongue and its attachments are then divided in the middle line, or to one side or other as may be desired, and the part to be removed dealt with exactly in the manner described for removal of the whole tongue. The advantages of the above opera-

tion, which can be performed in much less time than has been occupied by its description, are these :—

- (1) It is cleanly.
- (2) If carefully performed, there is no hemorrhage.
- (3) It is not followed by œdema of the neighboring parts.
- (4) It is quickly recovered from ; and,
- (5) It is, in my experience, not more but rather less liable than is the scissors operation, to be followed by any septic infection.

Circinate Eruption of the Tongue.

—Dr. D. F. Kinnier reports two cases of this rare lesion. Although the "spots" resemble those of ringworm, the author has never been able to find the trichophyton fungus. Parrot has considered the lesion syphilitic, but neither of these patients had traces of specific antecedents, and the affection, as described by the French observer, seems to present quite different characteristics. It may be due to gastrointestinal disturbance. It is generally looked upon as an affection of childhood, and it is more frequent in females. Little is known regarding treatment ; in these cases the lesion disappeared without treatment.—*The Med. Register*, March 16, 1887.

Five Cases of Large Visible Pulsating Artery on the Posterior Wall of the Pharynx, with remarks.—Dr. J. W. Farlou reports the above cases, illustrating an anomaly of surgical importance, especially in its relation to incisions in retropharyngeal abscesses. It is always advisable to examine with the finger, before operating, in order to exclude the possibility of an artery abnormal in size or situation.—*Bost. Med. and Surg. Jour.*, March 31, 1887.

On the Combination of Syphilis and Tuberculosis of the Larynx.—At the last meeting of German Naturalists and Physicians a paper was read by Schnitzler on the above subject. He says that the condition is frequent. Syphilitic ulcers may become transformed into tuberculous, these ulcers being good grounds for the development of the tubercle bacillus. The differential diagnosis is not easy. The constitutional as well as the local condition must receive attention.—*Jour. of Laryngol. and Rhinol.*, Feb., 1887.

In a communication to the *Pacific Med. and Surg. Jour.*, April, 1887, Dr. J. D. Arnold gives the history of a case illustrating laryngeal syphilis in a tubercular patient. Ulcerations upon the cords and

epiglottis healed in three weeks under mercurial treatment, while the arytenoid swelling and a deep inter-arytenoid ulcer showed not the faintest evidence of repair.

Excision of the Larynx and Pharynx.—Dr. D. Hayes Agnew reports a case of this operation, which resulted fatally in three days. No autopsy being permitted, it was impossible to determine the cause of death, whether from heart failure or pulmonary congestion. The tumor removed was a tubular epithelioma, involving the upper portion of the larynx, but not extending below the vocal cords. The fact of inclusion of the pharynx in the disease was not discovered until the operation was well under way, and the growth was supposed, until after its removal, to be a sarcoma, its vascularity prohibiting excision of a fragment for microscopic examination. The patient bore the operation very well, but narrowly escaped being asphyxiated on the second day by the ejection of a quantity of fluid from the stomach.—*Med. News*, Philadelphia, April 9, 1887.

A Successful Case of Partial Excision of the Larynx, on Account of Intra-Laryngeal Epithelioma.—Lennox Browne reports a case of excision of the left half of the larynx for epithelioma originating in the ventricle and involving the left vocal cord. A high tracheotomy was performed and Hahn's tampon-cannula introduced. A thyrotomy was then done ; the soft parts with the perichondrium were stripped from the cartilage by means of a raspatory.

Laryngectomy was effected by (a) further careful and thorough separation of the attachments to the pharynx by raspatory, knife-handle, and finger-nail ; (b) division of the thyro-hyoid membrane, as close as possible to its thyroid attachment ; (c) division of the left superior horn of the thyroid cartilage at its root by cutting pliers ; (d) division in the median line of the cricoid cartilage, before and behind, with pliers ; (e) the divided half of the larynx was then separated from the first ring of the trachea, and a few nicks only were necessary to remove it entire.

Hemorrhage was trifling, only two small vessels requiring torsion. In thirty hours the tampon-cannula was replaced by an ordinary trachea-tube, which was removed at the expiration of seventy-two hours. On the eighth day a sudden rise of temperature occurred, attended by marked dyspnoea.

The tube was reinserted and finally removed on the twentieth day. With this exception convalescence was not interrupted. Thirty-four days after the operation the patient was able to speak with a wonderfully good though rough voice. The right vocal cord was found to move freely, but was still somewhat congested; the structures on the left side of the larynx moved slightly towards the median line in phonation; the epiglottis acted perfectly and was exactly in position.

The operation of partial laryngectomy stands so far on a much more favorable footing, and the brilliant results of Eugene Hahn and other German surgeons have established it as one of far less immediate fatality than complete extirpation, and affording average periods of immunity from recurrence even of the more serious forms of malignant disease, which promise to be almost, if not quite, equal to those provided by tracheotomy.

Recurrence must, in the nature of things, be always anticipated; and we have yet to see what sort of history our cases will have in this respect. It is earnestly to be hoped that care will be taken in the selection of subjects for this operation, as otherwise discouragement will be given to its performance where other circumstances would be favorable. It is indicated in unilateral and intra-laryngeal epithelioma, and in recent non-filtrating sarcoma. It is useless in pharyngo-laryngeal epithelioma, in which the larynx is invaded from the pharynx, and whenever there is implication of the cervical glands and structures adjoining the larynx. It is always possible, if on division of the thyroid cartilage the disease is seen to have extended beyond the limits suspected by prior examination, for the surgeon to desist from removal and to be content with having performed tracheotomy.—*Brit. Med. Jour.*, Feb. 5, 1887.

Note on Preliminary Tracheotomy, as an Aid to Certain Operations.—By Thomas Annadale.—In operations involving the mouth, throat, or jaws it is important to prevent blood from passing into and obstructing the air-passages, and at the same time to secure free respiration with safe and convenient anæsthesia. In addition it is well that much blood should not pass down into the stomach, and so cause vomiting, which may interfere with the operation. After referring to an article by Dr. McBurney, in the *N. Y. Med. Jour.*,

March 24, 1883, the author describes an apparatus devised by himself as a substitute for Trendelenburg's tampon-canula. The instrument consists of a vulcanite tracheotomy tube, which has a broad ring attached to, but moving round, its neck, and of a piece of ordinary india-rubber tube about eighteen inches long, and having a diameter of half an inch. One end of the india-rubber tube is passed over the ring at the neck of the tracheotomy tube, and secured to it by a piece of strong silk, the ends of which are left long. The trachea or larynx having been opened, the tracheal tube is introduced as far as its neck, and then each end of the silk is, by means of a needle, brought through the corresponding edge of the wound in the skin, and when these are tied together they not only retain the tube in the trachea, but also close the external wound, and prevent any blood passing into the trachea in this way. The movable ring round the neck of the tracheal tube has the advantage that it allows of some corresponding movement of the tubing connected to it, so that the latter is much less liable to be twisted or bent, and its canal to become obstructed.

To administer an anæsthetic, the free end of the tubing is introduced into a glass or tumbler, in the bottom of which a little cotton-wadding is placed and upon this cotton-wadding chloroform or ether is dropped from time to time as may be required to keep up the anæsthesia. The tube and glass are held by an assistant at one or other side in the position which least interferes with the manipulations of the operator.

Immediately previous to the major operation, and after the tracheotomy has been performed, the throat is thoroughly stuffed by means of a piece of sponge or some cotton-wadding, which should be covered by oil-silk or other thin waterproof material, in order to diminish the chance of any blood oozing through the pad. It is well to attach to the pad a piece of strong silk or thread for the purpose of withdrawing it more readily.

Should the bleeding have ceased and there be no risk of swelling or œdema in the neighborhood of the glottis, the tracheotomy tube may be removed immediately after the completion of the operation, but if these favorable conditions are not present it is safer to leave in the tracheal tube, detaching the tubing from it, for twelve

or twenty-four hours, or for a longer time, according to the symptoms.—*Edinb. Med. Jour.*, March 1887.

Three Cases of Laryngeal Papillomata.—These cases, reported by Dr. G. W. Major, are of interest, as showing the effect of rest of the larynx, following tracheotomy, in retarding the growth of neoplasms, and the good results obtained from the use of laryngeal sprays of absolute alcohol. The author insists upon the importance of recognizing the fact that reduction of hypertrophied turbinated tissue and restoration of healthy nasal respiration must be secured before good results from local medication of the larynx can be expected. He believes that in two of these cases the development of papillomata might have been prevented had the nasal hypertrophies received early attention.—*The Canada Med. Record*, Jan., 1887.

Chronic Hypertrophy of the Ventricular Bands.—The use of resorcin, 15 to 20 grs. to the ounce of distilled water, is highly recommended in the above condition by Dr. Bernard Tauber. It is believed to act more deeply than ordinary astringents. In conjunction with the local treatment, rest of the voice is of the utmost importance, constitutional treatment must be followed when indicated, and, finally, an associated catarrhal condition of the pharynx and naso-pharynx must be relieved by local applications.—*The Cincinnati Lancet-Clinic*, Feb. 26, 1887.

Deep Tubing of the Larynx as a Substitute for Intubation.—Dr. A. E. Hoadley reports nine cases of what he calls "deep tubing" of the larynx. I having, in five cases, used the O'Dwyer tube, not with its flange resting posteriorly upon the arytenoid, so designed by its inventor, but reversed, the tube thus being permitted to descend more deeply within the larynx, the author became convinced that his accidental disposition of the tube was an improvement on the original intention. He therefore continued the practice and made the following observations: The ages of the patients ranged from two to six years. All had diphtheritic laryngeal stenosis. They were all bad cases and all died in from twenty-four hours to four days after the operation. The stenosis was promptly relieved in all. Eight out of the nine were able to drink several consecutive swallows immediately after the operation, and continued to do so as long as they could swal-

low. The eight suffered little or no pain from the presence of the tube, nor was the cough particularly troublesome. Four coughed but very little. In one the presence of the tube in the larynx did not excite cough; on the contrary, there was less coughing than before the tube was introduced. In one case the tube was coughed out, and a larger tube was introduced, which remained until the child died from extension of the exudate below the tube. In no case was there subsequent obstruction above the tube. In one case the obstruction seemed to be in the fauces and pharynx, and I feared that tracheotomy would be necessary, but "deep tubing" gave prompt relief. In two cases, while pressing the tube down deep into the larynx, it was felt to slip by an obstruction and pass beyond reach. In these two cases I believe the head of the tube was lodged in the ventricle of the larynx, resting upon the true vocal cords. There was no unusual inconvenience from the presence of the tube in this situation. I removed the tube in one of these cases and I had as little difficulty as in any, which I think would be equally true had the child been living. I might state while giving this opinion, however, that I have never extracted a tube from the living subject.

One case suffered severe and continual pain from the presence of the tube, and could not drink one drop without strangling and having a violent fit of coughing following the attempt; she was fed by means of a tube in the œsophagus. She died on the fourth day from pneumonia, the development of which was probably favored by the irritation of the tube. Her intolerance of the tube is attributed to certain changes in the pharynx and œsophagus, resulting from accidental swallowing of some concentrated lye two years previous.

The main objection to O'Dwyer's tube, namely, that it is apt to excite coughing at each attempt at swallowing, is obviated by the reversal of the tube. The extraction of the tube is believed to be easier when it occupies the deep position. The following modifications of the tube are suggested:

Shortening the tube to the length of the larynx, or perhaps a trifle longer.

Making the head of the tube conform more nearly to the shape of the interior of the upper part of the larynx.

Making the upper surface of the head of the tube slightly cup-shaped, for the pur-

pose of favoring the introduction of the extractor.

Having that portion of the posterior border of the tube which corresponds to the arytenoid cartilages, stand on a plane anterior to that of the rest of the tube, so that the pressure at this point may be slight. As the arytenoids are supported by muscles we should avoid putting them on the stretch. Constructing the obturator so that it will project three-eighths of an inch from the lower end. My tube, being a little shorter than the most convenient length for introduction, the longer tip of the obturator enables one to pass the tip to the proper position below the chink, when the tube should be detached, and pressed home with the finger before the obturator is withdrawn.—*Four. of the Am. Med. Ass'n*, March 26, 1887.

In the discussion on Dr. Hoadley's paper at a meeting of the Chicago Medical Society, Dr. F. E. Waxham presented a bronchocle which had caused death by compression of the trachea. Intubation was attempted but failed on account of the shortness of the tube. To meet similar emergencies, Dr. Waxham has had constructed a tube of much greater length than that for ordinary intubation. Exception is taken to Dr. Hoadley's plan of reversing the tube, for the reason that ulceration is apt to result from pressure of the shoulder of the tube, anteriorly. It is found, also, that the tube with the olive-shaped head fits the larynx much better than the original broad-shouldered tube, the use of which Dr. Hoadley proposes to resume. Care should be taken in selecting a tube to take one not too large; a suitable tube will sink into the larynx, rest upon the vocal cords, and produce but little difficulty in swallowing. Waxham, whose experience now includes over one hundred cases, also objects to shortening the tube, since the danger of occlusion, by detached pieces of false membrane, would be thereby increased. Dr. Henvotin, with rather a limited experience, favored the reversal of the tube. Dr. Ingals objected, on anatomical grounds, to inserting the tube the wrong way, for fear of ulceration. After intubation he strongly insists on withdrawal of fluids. The danger of bronchitis or pneumonia is much less when the patient is not permitted to drink. He prefers the long tube. With regard to the rubber attachment devised by Dr. Waxham, its inventor remarked that he had em-

ployed it in several cases with advantage. In closing the discussion, Dr. Hoadley still maintained the advantage of his plan, claiming that ulceration was rendered improbable by the low descent of the tube, the epiglottis not being in contact with it. The artificial epiglottis of Waxham is regarded not only as superfluous, but as an additional source of irritation.

DISEASES OF THE EYE.

ABSTRACTS AND SELECTIONS, BY A. T.

MUZZY, M.D.

Minor (J. L.), Sympathetic Eye Trouble.—In May, 1878, a young woman, 26 years of age, was attacked by purulent conjunctivitis which resulted in panophthalmitis and atrophy. In June, enucleation was performed as a preventive against sympathetic trouble. In August a permanent artificial eye was obtained. During the next fourteen months the patient traveled, and until April, or nearly eight months, the condition of the eye was satisfactory. But in April the socket inflamed, with a purulent discharge. By discontinuing the use of the shell the inflammation healed in three weeks, leaving a point at the centre of the socket slightly prominent and tender to the touch. But with this subsidence signs of irritation appeared in the sound eye. It being *bloodshot*, tender to the touch in the ciliary region, with photophobia. Near vision soon blurred with use of the eye, and induced pain. Distant vision remained unaffected. This sympathetic disturbance healed in one week under rest of the eye, and baths of warm water, leaving a permanent tenderness of the centre of the socket. The anxiety arising from this induced great care, with the giving up of all near work. The artificial eye was worn only for a few hours each day. In September, five months later, a similar attack appeared, which persisted until return to the United States in November. Examination then showed limitation of accommodation, and the retinal vessels a little full. The artificial eye was roughened. Rest in a darkened room, with the use of a new shell, worn only a few hours daily, removed all irritation, save tenderness of the stump. An operation was now performed to remove this, and was rewarded by finding a cyst at the end of the optic nerve, size of an Eng-

lish pea. Its removal was followed by healing, which was complete in three days. But in a month the old irritation reappeared, and during the next two years, over-use or exposure to bright light of the sound eye, proved an invariable cause of trouble. Use or disuse of the shell did seem to influence the attacks except when it was continued. Two of the points which make the case interesting, are: first, the rare sequence of sympathetic trouble following panophthalmitis; second, the equally rare occurrence of the development of sympathetic trouble when enucleation had been performed so long before any such symptoms had appeared.—*N. Y. Med. Four.*, March 19, 1887.

Williams (A. D.), Injury to Vision by Strong Sunlight.—The effect is that of focusing sunlight on any inflammable surface; it will burn. This focusing by the lens affects a minute portion of the retina at a time. A case recently examined showed a blind spot of only a quarter of an inch, two feet from the eye. All can understand that these burns may be slight when they will in time heal, but when deep they are permanent, though limited in extent. In Dr. Williams' cases the injury has always been permanent, no improvement having been noted.—*St. Louis Med. and Surg. Four.*, April, 1887.

The Effect of Excessive Illumination upon the Eye.—The exposure of the eye to intense light has been attended with many curious and unfortunate results. Professor J. Plateau, of the University of Ghent, while trying to observe the effects of irritation of the retina, gazed steadily at the sun for twenty seconds, and a chronic irido-choroiditis developed, which ended eventually in total blindness. The single flash of a sun reflector has been known to cause retinitis. Scotomata, amblyopia, and other temporary visual disturbances of a functional character have been frequently noted. A curious epidemic of snow-blindness occurred among a body of laborers engaged in clearing a way through masses of snow which obstructed the road between Passanaur and Mleti, in the Caucasus. The rays of the sun, reflected from the vast stretches of snow on every side, produced an intense glare of light, which the unaccustomed eye could not support without the protection of dark glasses. A few of the strongest were able to work with impunity, but the majority, especially the weakly and anæmic, suffered severely, in

spite of the various devices to protect them from the light. Among seventy strongly marked cases, thirty were so severe that the men were absolutely unable to continue their work or to find their way home. They were collected in a covered place, where they lay prone on their faces, striving to hide their eyes from the light, and crying out from pain. Photophobia was present in all the cases. Hyperæmia of the conjunctiva, with more or less injection of the ciliary vessels, and even chemosis, was found in all severe cases. Recovery was gradual, but complete. Dr. Andrews records a case of acute conjunctivitis brought on by exposure of the eyes to a 3,000 candle-power electric light. Workmen or others who expose the naked eye to an arc light of great intensity are liable to have conjunctivitis, as well as more serious ocular disturbances. It is estimated that exposure of the naked eye for one minute to an arc light of 2,000 candles will cause conjunctivitis. The violet or orange lights are said to be less injurious than the normal white light.

The light of lightning is too transient to cause any injury from simple retinal over-irritation; but cataracts sometimes follow lightning-strokes.

Glass-blowers suffer from an opacity of the lens, brought not by the light, but the intense radiant heat (148° F.) to which they are exposed during their work.

Of all forms of artificial illumination the incandescent electric light, so far as facts now go, is the best. Among 1,100 persons who worked by this light, Dr. Andrews found not a single case of injury. On the other hand many persons testified to the fact that they could work longer by it with less fatigue than with the gas or oil light. This is due, it is found, to the steadiness, absence of heat, and perhaps the greater proportion of violet rays. Short-sighted persons are, in particular, benefited by the use of the incandescent lamp.—*Edit., Med. Rec.*, N. Y., Feb. 19, 1887.

Keall (W. P.) on Evisceration of the Eyeball, with Introduction of Silver Artificial Vitreous.—The following is a modification of evisceration of the eyeball, as performed by Dr. Mules, of Manchester, inasmuch as a hollow silver ball was used, instead of the glass globe recommended by him.

CASE 1.—T. S., a boy, aged six, was admitted on May 3, 1886, suffering from

opacity and staphyloma of the cornea of the left eye ; the operation was performed on the day of admission, in the usual way ; the sclerotic was then intised in the horizontal direction about 5 millimetres on either side, and the largest-sized hollow silver ball that could with ease be introduced was enclosed in the sclerotic, which was accurately stitched together with fine silk, using very small curved needles. The conjunctiva was in like manner stitched over the whole, only in the contrary, that is, the perpendicular, direction, so as more effectually to close the wound.

Previous to the operation the conjunctiva, lids, eyebrows, and surrounding parts were purified with carbolic lotion, 1 in 20, and before introducing the ball the interior of the sclerotic was also swabbed out with the 1-in-20 lotion, and dusted with powdered iodoform ; the metal ball itself having, of course, been thoroughly purified, and the other usual antiseptic precautions taken, with the exception of the spray. The eye was afterwards dressed with a pad of boracic lint moistened with the carbolic lotion.

The evening temperature was 99° F. On the next day the lids, which were swollen and œdematous, were washed with carbolic lotion and dressed with boracic ointment, a little iodoform being dusted into the eye. The temperature in the morning was 97° F. ; in the evening 98.6° F.

On May 13th, on being told to look across the room, he opened both eyes, and the ocular conjunctiva of the left side was seen to be slightly swollen, and pressure through the upper lid to the silver ball did not cause pain.

On May 30th, about four weeks after the operation, he received a heavy blow on the left eye, producing the usual ecchymosis of the tissues in and around the orbit ; from this he recovered, with no more inconvenience than an ordinary black eye.

CASE 2.—C. D., aged fifty-three, a laborer and a hard drinker, was admitted on June 4, 1886, suffering from severe purulent (gonorrhœal ?) ophthalmia of the left eye, and slight conjunctivitis of the right eye. Notwithstanding the energetic treatment adopted, the details of which need not be entered into here, although the right eye recovered after a moderately severe attack, the left went on to sloughing of the cornea, protrusion of the iris, and the contents of the eyeball were about to escape. The

operation was performed, in a similar manner to that in the first case, on June 28th, about twenty-four days after the patient was admitted.

On July 12th the conjunctiva over the eyeball was still slightly red, and there was a slight discharge which stuck the lids together ; the movements of the eyeball were very good, and there was no pain. From this date the recovery was uninterrupted.

Although there has not yet been a case recorded in which the fragile glass ball has been broken by a blow on the blind eye, it was recognized as far back as the meeting of the Ophthalmological Society in March, 1885, when Dr. Mules exhibited his case, that such an accident was quite possible, and that the result would be a sclerotic filled with broken pieces of glass ; and this was regarded as a serious objection to the operation.

When in March last I suggested that a hollow metallic ball—say silver or gold—should be substituted for the glass, the proposition was met by three objections : 1. That the tissues would not tolerate the presence of the metal. 2. That a blow severe enough to crush the glass would bulge in the metal, and that accident would be as bad as smashing the glass. 3. The expense would be too great. As to the toleration of the silver by the living tissues, I felt very little doubt, having had considerable experience of the operations of suturing fragments of bone in fractures of the olecranon and of the patella, as well as in stitching together the pillars of the ring in hernia with pure silver wire, in all of which the wire was left in, and remains to the present time without producing the slightest irritation. These cases, which were shown at a meeting of the Bristol Medico-Chirurgical Society, Nov. 10, 1886, have justified that conclusion, more especially that of the man C. D. (Case 2), who was on the verge of *delirium tremens* when admitted into the hospital, and has been in the same condition since he went home. Further, at the time of operation, the eye eviscerated was in a condition of panophthalmitis, and the other was only recovering from a similar but slighter attack. Secondly, as to the injury inflicted by a blow. The lad T. S., whom I exhibited at a meeting of the Ophthalmological Society in June last (*Trans. Ophthal. Soc.*, vol. vi.) is a very good example, for he actually did receive a blow from falling against an iron bed-

stead, which would probably have broken the glass; at all events, it gave him a pretty severe "black eye," but no further harm. However, if the metallic ball had been bulged in, it would have been a very different matter to have had to make an incision through the sclerotic, remove the damaged silver ball, and introduce a fresh one, instead of an attempt to extract the spiculæ of broken glass had such an accident occurred to a person wearing the glass ball. Thirdly, as to the cost. It can scarcely be conceived that any reasonable cost should be an objection; but as the silver balls used, although they were made specially for me (by Messrs. Down Bros.) cost only four shillings each, the price can be only a very small objection.—*British Med. Jour.*, Feb. 12, 1887.

Bettman (B.) on Connection between Ocular and Nasal Diseases.—The source of many pathological conditions in the eyes and the lids is to be found in the nose. Thus epiphora of both eyes has entirely disappeared without direct treatment, on treating an oedematous sensitive condition of the turbinated bones. Removal of nasal polypi has also healed an excessive flow of tears with pain in the eyes. In another case, whenever the eyes were exposed to a glare of light, sneezing came on. Examination showed swelling of both nostrils. Cocaine applied to the nostril on pledgets of cotton arrested the photophobia. The usual application made is galvano-cautery.—*Chicago Med. Jour. and Exam.*, March, 1887.

Martin (E.) on Artificial Cornea.—Numerous operations have been performed to substitute the cornea of a rabbit for an opaque human cornea, but so far never with success; either the transplanted cornea has sloughed, or it has become opaque. Nussbaum tried the effect of inserting a glass cornea, but without success, since it could not be retained. This operation proceeds on a different principle. The globe is rotated about 45° by division of one rectus and advancement of its opponent; a trocar and a small gold canula are thrust through, the sclerotic brought forward; the trocar is withdrawn, but the canula is left in the eye, and the conjunctiva is united over it. When all conjunctival injection has subsided, the membrane is destroyed over the canula with the galvano-cautery, and a little conical glass stopper measuring two millimetres in length, and

one in diameter at its widest or external end. This is to admit and refract rays of light. The operation has only been practised upon eyes which were too much disorganized for any visual improvement to be expected, but the tolerance of the eye to the instrument may, the author considers, be held to be established. Even if the operation could be shown to be free from danger, it is difficult to see how much improvement in vision could result from light being thrown upon so peripheral a part of the retina, as it must be in the position which the canula occupies, and it seems quite improbable that it will prove of any practical utility.—*Ophth. Rev.*, Oct., 1886, in *London Med. Record*, Jan. 15, 1887.

Türevitch (E. L.) on the Influence of Cocaine on the Absorption of Drugs from the Conjunctival Sac.—Dr. Türevitch, of St. Petersburg, states that both clinical and physiological experiments of his have proved that cocaine possesses a power of promoting the absorption of drugs from the conjunctival sac. He experimented chiefly with eserine and pilocarpine. It is well known that both of these drugs are antagonists of cocaine, as far as their action on the pupil and accommodation is concerned. To study the matter, the author took a series of comparative observations on himself and other persons; in each case the course of the spasm was watched first without cocaine and then in a cocaineized eye. He found (1) that the eserine spasm invariably lasted longer under cocaine, the difference varying from ten to forty-five minutes; (2) that the average height of the spasm was invariably greater under cocaine; (3) that in eight of twelve cases the maximum of the spasm was higher in the case of the cocaineized eye. The explanation may be sought and found in the supposition that the conjunctival sac of a cocaineized eye must absorb solutions of the drugs instilled more than a non-cocaineized conjunctiva; (1) an anæsthetized eye (with insensitive cornea and conjunctiva) ceases to wink and compress the eyelids; in other words, ceases to expel foreign fluids introduced into the conjunctival sac; (2) the secretion of tears being lessened, the solution introduced into the sac remains less diluted and cannot be washed out (in the case of a cocaineized eye); (3) the conjunctiva and cornea themselves become dry, and hence more able to absorb any solution

introduced into the sac. Dr. Türevitch's hypothesis is confirmed also by the fact that when cocaine and eserine (or pilocarpine) are introduced simultaneously (that is, when the latter begins to act before the cocaine anæsthesia could be established), the accommodation-spasm shows exactly the same intensity as in the case when eserine or pilocarpine alone is instilled; that is, it shows a by far lesser intensity than in a previously cocaineized eye.—From the *Vratch*, 1886, p. 841, in *London Med. Record*, Feb. 15, 1887.

SURGERY.

Wright (J. W.), Three Cases of Hydrocele in the Female.—In one case there was a fluctuating tumor the size of a pigeon's egg just above the inner half of Poupart's ligament of the left side. It had not been very painful until recently, when it had increased in size. It was irreducible. No impulse on coughing. A needle drew from it clear, straw-colored serum. It refilled in two days, when the fluid was again withdrawn and the sac scarified with a needle. This was followed by inflammation, and resulted in a cure.

In the second case there was a soft fluctuating tumor of the size of a pigeon's egg in the right inguinal region, just above the middle of Poupart's ligament. The tumor seemed to consist of two portions—viz., a larger sac superficially, and a smaller one somewhat more deeply situated. There was no impulse, and the tumor was irreducible. The patient said the swelling had occasionally presented itself ever since the birth of her first child, and that she had been in the habit of pushing it back with her hand.

Three weeks before, while lifting one of her children, the present tumor had suddenly made its appearance, and she had been unable to reduce it as before; since then she had suffered more or less from colic, flatulence, constipation, etc. The tumor was sensitive to the touch, and the skin covering it somewhat inflamed from her frequent efforts at reduction. The patient was ordered to bed, with hips elevated, and an ice-bag to be applied to the swelling at intervals until the next day.

The following day the tumor was operated. There were two distinct sacs, and each was scarified and a cure followed.

The third case was one of a tumor, size of the last joint of the thumb, just above Poupart's ligament on the right side, and was cured by repeated aspirations.

Dr. Wright mentioned the following points as being of clinical interest:

1. The rarity of the affection. It had been ignored by most surgical writers until within the last few years. Fewer than forty cases had been reported.

2. The liability of its being confounded by the surgeon with irreducible hernia.

3. Its resemblance to strangulated hernia when suddenly inflamed.

4. The diagnosis being easily settled in doubtful cases by the hypodermic needle.—*N. Y. Med. Jour.*, March 26, 1887.

G. B. P.

Claybaugh (N. W.) on a Case of Spontaneous Cure of Hernia with Incidental Loss of a Testicle.—I was consulted by a worthy couple recently for an opinion as to the reason of their sterility. The husband denied ever having had gonorrhœa or any venereal disease. I drew out of him the information that when eighteen years old (he is now thirty-three) he was ruptured; that for a while he wore a truss, but at last he was unable to get one which he could wear comfortably, and took to wearing a suspensory bandage. Then he took sick with cramps, which lasted for three days. All this time he had no doctor. When his cramps were gone, so also was his rupture, and with it his testicle. Since that time his belly has been "as hard as a rock." And, in fact, below the umbilicus his abdominal walls *are* hard—will not yield to the fingers or to any pressure brought to bear on them.—*Med. and Surg. Reporter*, March 12, 1887.

Clarke (B.) on Conditions in Children Simulating Stone.—The particular condition he referred to was a roughness of the mucous lining of the bladder and its coating with hard gritty particles. He quoted two cases which he had had under his care, where the most characteristic symptoms had been produced, and which had yielded to alkalies, milk diet, and rest in bed. Mr. Parker pointed out that the symptoms of stone in girls were very different from those in boys, consisting chiefly in tenesmus and diarrhœa. Mr. Marmaduke Sheild quoted three cases of pelvic sarcoma in which the symptoms closely resembled those of stone. Mr. Henry Morris pointed out that the condi-

tion described was dependent on over-acidity of the urine causing cystitis. When this acidity was corrected the condition disappeared.—*Med. Press*, March 16, 1887.

Miller (T. W.) on Foreign Body from the Bladder.—A roll of chewing-gum, two inches long, partially encrusted with urinary salts, was removed from the bladder of a young man. The patient, suspecting he had a stricture, had explored his urethra with a well-masticated roll of chewing-gum stuck upon the end of a broom straw. When the straw was withdrawn the gum had disappeared. Acute cystitis ensued. Attempts to detect and extract the gum with a small lithotrite having failed, perineal urethrotomy was performed and the gum extracted by the finger. Patient entirely recovered in two weeks.—*Jour. Am. Med. Ass'n*, March 12, 1887.

Cotting (B. E.). A Few Fragmentary Remarks on the Radical Relief of Infleshed Toe-Nail.—The author thus describes the excellent operation known as Cotting's for ingrowing toe-nail: "Etherize the patient, unless he object. Remove with the knife the diseased fleshy parts, *together with a large and thick slice* of the healthy and adjoining side of the toe. Let the cut begin on, go well back, and let it be guided by the edge of the nail, which should be exposed, but need not, nor its matrix, be involved or injured thereby.

"Bleeding during the operation can be prevented by a rubber tube being wound about the toe, Esmarch fashion.

"Dress the wound with lint or absorbent cotton, firmly compressed upon it by a narrow roller-bandage, and cover the whole with a good-sized piece of oiled muslin or silk, neatly secured, in order to prevent any extra oozing of blood."

This is the whole of it. The patient lies abed for a few days, or immediately sits up, or hobbles about, as he pleases, even going to his work at once, if necessary. From the moment of the operation there remains only a clean-cut wound, to heal as other wounds of like dimensions, with less pain or annoyance in it than previously in the disease; while such as there is, rapidly decreasing, soon departs altogether.

This operation, one of the simplest ever devised for this affection, differs from all the others in its fundamental principle and purpose, namely, the producing of a radical cure by *cicatricial contraction*, and that

by means of a wound of sufficiently large extent, in healthy as well as diseased parts. For, as such a wound heals, the remnants of the lateral fleshy nail-furrow, if any remain, together with the soft parts adjoining, are drawn in by the contraction, and, in this manner, are kept away from the edge of the nail. Thus the nail thence after, in its ordinary growth, has nothing to imbed itself in, or even to impinge upon. A return of the affection is thus put entirely out of the question.—*Bost. Med. and Surg. Jour.*, April 7, 1887.

[Twelve to fifteen minims of cocaine injected beneath the skin at the side of the distal phalanx render the operation painless, if the incision is not made too soon.—G. B. P.]

Morris (Henry) on Pylorectomy for Carcinoma; Death; Necropsy.—The patient was a woman aged thirty-nine, who had suffered from dyspepsia many years. Nine weeks before admission to the hospital, had an attack of jaundice lasting a month, and with it constipation, nausea, and vomiting. At this time noticed a "lump" in upper part of abdomen.

When admitted she could not retain food, and was emaciated. For eleven days she was fed with nutrient enemata, but after this time could retain them no longer. It was then decided to operate.

An incision four inches long was made a little to right of umbilicus, and the tumor, which was freely movable, was readily brought out of the opening made and excised. The stomach and duodenum were then united by silk (?) sutures. The patient died on the fourth day, and the autopsy showed general peritonitis. At the posterior and upper part of the wound, near where the occlusion sutures joined the ring sutures, some of the latter had ulcerated through, leaving a gap through which the contents of the stomach had escaped into the peritoneal cavity. [It is at this point that there is always the most difficulty to securely unite the edges of the wounds together.—G. B. P.]—*Brit. Med. Jour.*, Feb. 12, 1887.

Wylie (W. G.). Observations on the Use of Hot Water within the Peritoneal Cavity during and after Laparotomy to Prevent Shock; Treatment of Septic Peritonitis and Intestinal Obstruction by the Use of Purgatives.—In a report on one hundred and twenty-five laparotomies performed by

the author, he gives in detail an account of two cases in which he used hot water in large amounts in the peritoneal cavity, and in which he used purgatives in the treatment of peritonitis.

One case is as follows :

"The tumor was adherent to nearly every thing in abdominal cavity ; the omentum was tied off, and several points tied in the cavity near the liver and stomach, and deep in the pelvis. After the pedicle was tied and the tumor removed, the oozing was checked by the free use of hot-water irrigation to the whole peritoneum, by means of a large fountain syringe, with a rubber tube of large lumen attached.

"I noticed that not only was the bleeding checked by the hot water, but that the indications of shock, which were present to an alarming extent—that is, very feeble heart's action, cold perspiration, etc.—were at once relieved by the hot water. Some time was taken to sew up the wound and get her ready for bed, and as there was some return of the symptoms of shock, a gallon of hot water— 105° to 110° —was allowed to flow into the closed abdominal cavity by means of the glass drainage-tube that had been inserted, and this was squeezed out and another gallon allowed to flow in and emptied out.

"The result was magical. After this the symptoms of shock did not return, and at no time was there a subnormal temperature.

"After this she did well until the third day, when the gradual rise of temperature and marked tympanites indicated septic peritonitis.

"A turpentine enema was given. Very little flatus and no fecal matter passed ; but soon the temperature in the axilla reached 104° , and frequent vomiting of coffee-colored fluid began, and pulse ran up to 140, and there was a slight, irritating cough. Her condition seemed hopeless. Knowing from experience that septic poison is nearly always modified by a free movement, and firmly believing that intestinal obstruction exists in some of these cases from lymph adhesions, necessarily so numerous and extensive, I determined to try and secure a movement by means of a quick purgative.

"A full-sized seidlitz powder was given, and supplemented an hour later by an ox-gall enema. A copious brownish-colored liquid movement was the result. After

this the vomiting ceased. Nutritive and stimulating enemas were given every three hours, and small quantities of kumyss given by the mouth. The drainage-tube worked well, and large quantities of bloody serum were drawn off three or four times each day. She made a slow but steady recovery, and went home well in seven weeks."

The writer, in concluding the paper, says : "That hot water cannot only be safely used to wash out the peritoneal cavity, and that it is a simple and efficient hæmostatic for oozing points too numerous and small to tie ; but that in prolonged operations, and immediately after the operation, free irrigation of the peritoneal cavity with water at 105° to 110° is a powerful and efficient agent, it lessening, if not preventing, the effects of shock.

"*Second.*—That the tympanites and vomiting and other symptoms supposed to be due to septic peritonitis after laparotomy, are best overcome by enemas, and if these fail, by a quick purgative. That in these cases, at least, the bowels should be moved, and not kept constipated, as has been generally practised. That it is probable that in many cases the persistent and exhausting vomiting may be the direct result of intestinal obstruction, the result of bands of adhesions constricting the intestines. For a long time I have seriously doubted the existence of septic peritonitis in some cases where the vomiting preceded the rise of temperature and other symptoms of sepsis. By experience I have found it best to move the bowels whenever indicated by tympanites or vomiting, even during the first twenty-four hours after the operation—of course, making a distinction between these symptoms and those due to the effects of ether. The vomiting from ether is likely to be preceded by marked nausea, and is usually violent and gagging in character, while that from obstruction is passive and more like eructation. The quantity vomited is large, and at first brownish-colored, and attended with extreme exhaustion and marked tympanites. Without doubt the opium treatment taught by Dr. Alonzo Clark has proved to be the best plan for limiting local peritonitis, and when carefully carried out, may prevent death in some cases of general peritonitis ; but I am certain that it is not best suited for septic peritonitis following laparotomy. I usually give enough opium or morphine

to relieve pain and restlessness, and keep the respiration down to 16, or even 12 in some cases. But when tympanites or eructive vomiting begins, I at once move the bowels by turpentine or ox-gall enemas, or by a seidlitz powder or Rochelle saltz."—*N. Y. Med. Record*, March 19, 1887.

G. B. P.

Croft (J.) on Rupture of the Intestines.—On March 6th Mr. Croft, of St. Thomas' Hospital, performed abdominal section on a patient, aged thirty-four, who had been admitted with acute peritonitis due to injury received about eighteen hours previously. The patient, who had received severe injury to the abdomen the night before, walked to the hospital. He had vomited, and in addition to the symptoms of most acute peritonitis and a temperature of 103° , had some dulness in the hypogastric region. A rent was found almost dividing the small intestine; there was feculent material in the peritoneal cavity, and acute inflammation in the neighborhood. The peritoneum was washed out with a twenty-per-cent solution of boracic acid, and the intestine sutured to the wound. Since the operation his progress has been very satisfactory; he has had neither pain nor vomiting, and the distension of the abdomen has disappeared. Although he was complaining of cough and had a rapid pulse, his condition was otherwise favorable on the 10th. The same surgeon operated on the 4th, in a case of abdominal injury, accompanied by much hemorrhage into the peritoneal cavity, and removed the spleen, the hemorrhage being due to an extensive laceration of that organ. The patient, however, did not survive the loss of blood and the additional shock of the operation.—*Lancet*, March 12, 1887.

Pneumotomy in Pulmonary Abscess.—Dr. Runeberg, Professor of Medicine at Helsingfors, in a clinical lecture which has been published in a Swedish journal published in Finland, gives an account of a case of pulmonary abscess consequent on acute pneumonia, where he had performed pneumotomy with success. In addition to this he had collected notes of ten other cases. Leaving aside three of the eleven, on account of uncertainty in the diagnosis, five of the remaining eight recovered, or at all events improved very decidedly, and in the rest, which were fatal, death could not in any way be attributed to the operation, so that Dr. Runeberg con-

siders that when the diagnosis of pulmonary abscess is clear, and it is in an accessible situation, the best practice is certainly to open it. He then refers to the question of operating for gangrene of the lung. He himself had had a case of this, together with bronchitis and bronchiectasis; after the operation secondary gangrene and septicæmia occurred, which proved fatal. In seventeen other cases of gangrene he quotes from medical literature where pneumotomy was performed, seven recovered more or less completely, and the fatal termination of the remaining ten did not appear to have been attributable to surgical interference. As to the method of opening the lung, Dr. Runeberg is in favor of resecting a rib, and then using the thermocautery. He does not approve of washing out the cavity with antiseptic lotions, thinking them dangerous, and believing that ample drainage is sufficient. In conclusion, he mentions several pneumotomy cases he had collected: two were for ecchinococcus, both terminating favorably; six were for bronchiectatic cavities with gangrene; and six for tubercular cavities. In the latter two classes of cases he does not think operative procedures are advisable. *Lancet*, Feb. 12, 1887.

Annandale (T.) on Displacement of the Inter-Articular Cartilage of the Lower Jaw, and its Treatment by Operation.—An incision, slightly curved, about three quarters of an inch in length, is made over the posterior margin of the external lateral ligament of this joint, and is carried down to its capsule. Any small bleeding vessels having been secured, the capsule is divided, and the inter-articular cartilage is seized, drawn into position, and secured to the periosteum and other tissues at the outer margin of the articulation by a catgut suture.—*Lancet*, Feb. 26, 1887.

Ring Pessary in Treatment of Fractured Patella.—A subscriber to the *Maryland Med. Jour.* (March 19th) writes: "I desire to call attention to the simple, inexpensive, and efficient plan of treating fracture of the patella. The only articles required are, a gum ring pessary, two strips of adhesive plaster two inches wide and long enough to go round the limb, one above and the other below the knee, and a few yards of muslin bandage.

"Bring the fragments as closely together as possible and encircle with the ring;

secure the ring in position by two strips of muslin passing through it and connecting with the adhesive strips. Then bandage well. With this treatment considerable latitude of motion may be allowed the patient in bed without injury, and in most cases he may be allowed to sit up in three weeks.

"Six cases have been treated in this way within the last ten years, all of which have resulted satisfactorily.

Goodfellow (G. E.) on the Impenetrability of Silk to Bullets.—A somewhat extensive experience in the gunshot wounds of civil life, during the past few years, has brought to my attention the following instances illustrative of the remarkable tenacity of silk fibre and its resistance to the penetrative power of a bullet:

In the spring of 1881 I was a few feet distant from a couple of individuals who were quarrelling. They began shooting. The first shot took effect, as was afterward ascertained, in the left breast of one of them.

Upon stripping the body, I found not a drop of blood had come from either of the two wounds received. From the wound in the breast a silk handkerchief protruded, which I presumed had been stuffed in by some of his friends to prevent bleeding. I withdrew it, and with it came the bullet. It was then seen that it had been carried in by the ball.

Upon opening the body, the track of the ball was found to be as follows: through the left ventricle, thence through the descending aorta; thence into and through the body of either the second or third dorsal vertebra into the spinal canal, fracturing the laminae. The ball came from a cut-off Colt 45-calibre revolver, fired at a distance of six feet, the cartridge of which contains thirty grains of powder and two hundred and sixty grains of lead. The man had on a light summer suit, the handkerchief being in the breast pocket of the coat.

Examination of the handkerchief showed only two slight tears or cuts in it, they being on the outside of the fold containing the bullet, where it had struck the bones of the vertebral column, no ribs having been touched. There were two thicknesses of silk covering the bullet.

In a short time a still more remarkable case was observed. During a fight a man was wounded at a distance of thirty feet by

a load from a shotgun. The cartridge contained four drams of powder and twelve buckshot. Four of the shot penetrated the frontal bone, and, as shown by the autopsy, flattening themselves against the posterior wall of the skull; more entered the face, piercing the facial bones, and some passed through the upper thoracic wall, thence into the lungs. At the time he was shot he had loosely tied about his neck a red-silk Chinese handkerchief. In the folds of this I found two buckshot, neither of which had so much as cut a fibre of the silk. There were four or six folds of the silk between the balls and the skin. The uncertainty as to the number of layers arises from the fact that, not wishing to damage the specimen, I never have unfolded the handkerchief to ascertain exactly.

The third case was that of a man wounded at a distance not exceeding three feet, by a ball from a full-length, 45-calibre Colt revolver. The ball entered the right side of the neck two inches below the angle of the jaw at the posterior border of the sterno-cleido-mastoid muscle and emerged on the left side at the angle of the jaw. The head was turned slightly to the right at the time the bullet struck him. Around his neck was loosely tied a red silk handkerchief, as in the preceding case. The ball catching this carried a portion of it through to the wound, then slipped off, leaving the handkerchief in the wound uncut.—*So. Califor. Pract.*, March, 1887.

GENITO-URINARY AND SYPHILIS.

Byrd (W. A.) on Cervical Bubo and Orchitis, as Complications or Sequelæ of Typhoid Fever.—During the early spring of 1881 I was treating an Irish girl, aged eighteen, for typhoid fever, which was of a rather severe type. On the twenty-fourth day from the time she went to bed with the fever, the parotid gland of the right side began to inflame and enlarge. In about a week I made an opening with a scalpel through the middle of the swelling. A large quantity of pus was discharged, and, taking up dead tissue with the forceps, the whole of the parotid gland came away, leaving a very deep cavity in the neck. This slowly filled by granulation. The girl made a slow but perfect recovery.

Since that time I have seen but two cases of parotitis following typhoid fever; in neither was there suppuration, and both got well.

Having neither read nor heard of epididymitis or orchitis being a complication or sequel to typhoid fever, perhaps it will be as well to put on record the following case: A strong young man, twenty-three years old, of German parentage, was taken August 20, 1886, with diarrhoea and fever, the thermometer marking 105° F. The fever followed the usual course of typhoid, there being the dry tongue, tympanites, diarrhoea, delirium, and rose-colored spots. He had been complaining two weeks before going to bed. After the 5th of September he began to convalesce, but had two chills; just what days I did not record, but during the afternoon of Sept. 16th he had a violent chill and great pain in the right testicle, which rapidly swelled and became very red. I had the ice-water coil replaced upon his head and raised the testicles, by placing a bridge, made of a broad piece of rubber adhesive plaster passed across the thighs. Then hot applications were made to the swollen testicle, but the heat was unbearable, and was replaced by the ice-bag. His fever reached as high as 103° for over a week, when it decreased, as did the swelling in the testicle. Oct. 13th he was discharged.

The young man had never had any form of venereal disease. The catheter had been used to draw his urine at a time when the fever was at its worst, but had not been used for over two weeks before the orchitis began. There was no discharge of pus from the urethra at any time.

The convalescence was slow, but the young man at this time is a perfect picture of health.—*St. Louis Med. and Surg. Jour.*, March, 1887.

Reid (J.) on Orchitis in a New-Born Child.—The following case, if of traumatic is worth recording, if of syphilitic orchitis is noteworthy on account of its early appearance. The child, F. W. B., was brought to me on the 20th Nov., 1886. The mother says it always had a cold (snuffles), and that the woman in attendance at the birth noticed the left scrotum large, but said it was nothing. There were ulceration at the navel, slight bronchitis, and thrush, with snuffles to a small extent. The scrotum on the affected side was congested at parts, boggy in feel, and very slightly, if at

all, tender, as if containing fluid, opaque, and the testicle was enlarged uniformly to about $1\frac{1}{2}$ times the natural size. Under mercurial inunction, testicle and scrotum reached their natural size on the 25th. On the 26th, change of weather metamorphosed the bronchitis, which they refused to have treated, into broncho-pneumonia (catarrhal pneumonia), and the child, at the age of fifty-five days, died at midnight from exhaustion. There was no autopsy.

The parents have been healthy, and the brothers and sisters, although pasty in appearance, have never exhibited signs of syphilis. The teeth are slightly notched in some of the children. A brother survived a severe attack of typhoid complicated with pneumonia, but uninfluenced by mercurials. Mother's brother (uncle) was treated by me for over a year for psoriasis of the leg, which yielded to anti-syphilitic treatment with chrysophanic acid locally applied. He denied ever having had connection, and his age is 23. Thus, if the disease is syphilitic, which I believe it to be from the uniformly enlarged hard testicle and the presence of snuffles, it must be the product of latent syphilis, just as that of its uncle's was. From the life of the uncle, J. A. F., I have reason to believe his statement, and also his assertion when he said he never suffered since childhood. There was no known cause of injury; the labor was natural.—*Australasian Med. Gazette*, Jan., 1887.

Muskett (P. E.) on an Unusual Site for Hydatid Cyst; an Addition to the Recognized Varieties of Intrascrotal Disease.—The patient, A. T., æt. twenty-five, a native of Lancashire, was brought out to Brisbane by his parents in 1864, when he was three years of age. In 1874 he was residing at Gympie (Queensland), a gold-mining township, situated in a sheep district, where the water is very bad, being obtained from water-holes sunk in the ground. In 1878 he first noticed a swelling in the right scrotal region, which began at the lower part and enlarged from below upwards. The swelling at the beginning of 1884 was nearly the size of "two shut fists," and immediately prior to this had enlarged very rapidly. It caused such dragging pain from its weight that he at last sought advice, and consulted the late Dr. Macartney, who tapped him and drew off nearly half a pint of "dirty-looking fluid." After this tapping it began to swell

again, and soon reached its former size. Eight months afterwards he consulted Dr. Macdonald, who re-tapped him, withdrawing not so much fluid as on the first occasion, about a quarter pint, which was much clearer than in the former instance. The latter surgeon then injected iodine into the sac, which did not give rise to much constitutional disturbance; but in three or four weeks' time it began to swell, and rapidly attained its old dimensions.

He subsequently found his way to the Sydney Hospital, and was admitted July 16, 1886. There was an intrascrotal tumor about the size of a large emu egg on the right side. It was smooth in outline, and in its general contour nearly oval. The tumor was tense and dull on percussion, but gave to the fingers on palpation the sensation of fluid within. There was no impulse on coughing, and it was irreducible. The position of the testicle, at its posterior part, was made out by the presence of testicular sensation. The cord could not be clearly defined at the upper portion of the swelling. Light was transmitted by the ordinary manner of procedure, and finally, as was mentioned previously, the history had been that of an eight years' growth, painless except from its mere weight.

The house surgeon, on July 17th, the day after admission, tapped him with a fine exploring trocar and canula, and evacuated about one ounce of "serous-looking fluid," of "pale yellowish tinge." A few days afterwards his temperature rose repeatedly every evening two or three degrees above the normal, being attended with much heat and swelling about the tumor. I now determined (July 30th) to empty its contents, and for this purpose used a full-sized trocar and canula, giving exit to about six ounces of purulent-looking fluid. After this a good deal of pus daily drained away, and feeling satisfied that there was something demanding freer outlet, I proposed (August 10th) to open up the scrotum antiseptically on the following morning, insert a full-sized drainage tube, and then stitch the cut edges of the tunica vaginalis and integument together. In the afternoon of the same day, however, an hydatid sac partly forced its way, and was partly extracted, through the opening left from the tapping ten days previously. It presented the usual and unmistakable characters of an hydatid sac, being grayish in color, translucent and elastic, and in its collapsed

condition was of such a size as would about fill an egg up.

From this time the swelling gradually subsided, the sinus ceased to discharge, the scrotum returned to its normal condition, and the patient was subsequently discharged, cured.—*Med. Press*, Feb. 16, 1887.

Boone (D. W.) on a Unique Penis Syringe.—It consists of a glass tube or barrel three and a half or four inches in length, half an inch in diameter, conical at one end to fit the meatus urinarius, and to the end is attached a hollow rubber ball, an inch or more in diameter. By compression and expansion of the ball, fluid can be drawn up and forced into the urethra and returned to the syringe, thus perfectly washing the urethra, the desideratum in urethral injections.

A word as to directions: After the syringe is partly filled, the conical end is snugly fitted to the meatus, and by raising and compressing the ball, the fluid is forced into the urethra; then lower the ball and let it expand, and the fluid is again returned to the syringe. By this manœuvre the injection can be changed and a complete cleansing of the urethra effected. With the barrel of a common glass syringe and a small rubber ball, I made a very good instrument.—*Med. and Surg. Reporter*, Feb. 12, 1887.

Gould (P.) on a Horny Growth on Penis.—The patient was a man aged 50, who had had congenital phimosis. He first experienced difficulty in micturition about four years earlier, and was circumcised; the wound healed except in the middle line, where a small granulating surface remained; in connection with this surface two small warts developed; from the earliest formed a discharge commenced and continued up to the time he came under Mr. Gould's care. On the middle of the upper surface of the glans was a sessile truncated horn of yellowish color, translucent, and of the size of a small marble. The penis was amputated, the inguinal glands removed, and the patient rapidly recovered. Microscopic sections of the horn prepared by Mr. L. Hudson, showed the usual epidermal structure, the cells being flattened, nucleated, and in regular superposed layers; no enlarged papillæ entered the base of the horn; the ulcer was epitheliomatous; the glands showed no secondary deposits. Reference was made to Sir Erasmus Wilson's collection of ninety cases of horns, of which five were on the penis, and to the

later collection made by Lebert, of a hundred and nine cases, from various sources, of which six were on the penis. Mr. Gould also mentioned other cases, and stated that his specimen was the fourteenth recorded case of horn on the penis. Some of the horns had reached a great size; in one recorded by Mr. Jewett the horn was three inches and a half long, and three-quarter inch in diameter. In another recorded by Pick, the horn was two inches and a half long; in the case recorded by Mr. Gould, the patient was in the habit of paring the horn down. It had been shown that the horns originated in three different ways: from the interior of sebaceous cysts, which was the most frequent mode; from the matrix of nails; and from some change occurring in warts. Those on the glans penis belonged to the last group. Histologically they fell into two classes, the papillary and flat; the specimen shown was of the latter kind.—*Br. Med. Jour.*, Feb. 19, 1887.

Sutton (B.) on the Diseases of the Genito-Urinary Organs in Animals.

The first specimen consisted of the kidney of a sloth which had lived in the Zoological Gardens twelve years. Occupying the pelvis of the kidney were two calculi; one was small, and weighed 2 grains, the other weighed 12.8 grains. Chemically they were found to be composed principally of oxalate of lime. Although renal calculi were not uncommon in domesticated animals, they seemed to be excessively rare in wild ones. A remarkable case of distension of the vaginal, cervical, and uterine cavities of a hog-deer was described; the uterous of an agouti was also shown, in which some pieces of placenta and foetal membranes had been retained. Inflammation and supuration of the mucous membrane (suppurative endometritis) had resulted; the pus made its way along the left cornu and Fallopian tube, and an abscess formed in the ovary which ruptured into the peritoneal cavity, giving rise to fatal peritonitis. Details of a case of inflammation of the oviduct of a fowl were related. The bird during life laid eggs of very small size, and without yolk. When the bird was killed, the infundibulum of the oviduct was found adherent to the ovary, so that the ova could not fall into the duct, but the albumen at the same time secreted by the oviduct became coated with shell, and was laid on a small yolkless egg. The pelvis of a baboon was shown, with the viscera *in situ*. The

uterus presented a severe retroflexion. During life the animal exhibited well-marked symptoms, which were attributed to the condition of the uterus. Some remarks were made regarding the existence of ripe ova, and mature follicles in the ovary of the human foetus, and in those of the embryos of various and diverse species of mammals.—The president thought that it was difficult to overestimate the value of researches, such as those which Mr. Sutton was so ably conducting, owing to the light which might be thus thrown on the whole process of pathology. The cases illustrated the influence of the conditions under which human life now existed, in animals not born into those conditions. In man it was difficult to distinguish between the operation of heredity and of external conditions; in animals of wild species, the influence of heredity, which could never be excluded in men, could be completely excluded. It was of greatest interest, under the circumstances, to trace in them the occurrence of diseases which were encountered in man. He inquired whether there was any material differences in the diseases noted in wild animals dying just after importation, when they might be regarded as in their wild state, and those observed after they had been subject to confinement and town influences.—Mr. Bland Sutton, in reply, said that when an animal was imported, it either became acclimatized, or died within twelve months.—*Br. Med. Jour.*, Feb. 5, 1887.

Sturgis (F. R.) on the Supposed Virus of Chancroid.

—The author cited a number of experiments going to prove the position which he accepted,—namely, that there was no virus of chancroid. It was the result of an acute inflammation; its source, while frequently from another chancroid during venery, might also be from irritation in any other wound. Gonorrhœal pus, for instance, had given rise to the chancroid when applied to an abrasion or sore, and this chancroid was capable of auto-inoculation like any other chancroid. But its auto-inoculative property was usually less tenacious.—*Med. Times*, March 19, 1887.

Inflammation of the Submucous Tissue of the Glans and Prepuce.

—At the meeting of the New York Surgical Society, held Nov. 8, 1886, Dr. Geo. A. Peters reported a very rare condition of the penis, for the relief of which he had

resorted to amputation of the organ, fearing that it might degenerate into epithelioma. The patient was sixty-five years of age, and the disease had begun about two years previously with pain in the penis, followed by changes which had rendered the glans and prepuce hard and unyielding. Pain, itching, and burning had been constant symptoms, and the patient had become almost hypochondriacal in consequence. Thirteen days after the operation, the patient was well. Microscopical sections showed inflammatory zones, and extending from them zones composed of small round cells (young cells) accumulated in places as in abscess formation, but without any tendency to break down. There was nothing to indicate carcinoma or sarcoma.—*Four. Cut. and Genito-Urin. Diseases*, Feb., 1887.

Stricture of the Female Urethra.

—Two cases of this uncommon ailment have recently been reported. Dr. T. A. Ashby reports a case of stricture of the urethra in a mulatto woman. The urethra was almost entirely closed and urine could only be voided drop by drop. One stricture was located at the external meatus, and another about midway of the canal. The urethra would only admit of the passage of a very small probe. Dilatation was accomplished until a No. 12 catheter was passed. The cause of the stricture could not be altogether satisfactorily accounted for. There was no history of gonorrhœa or of syphilis. The mucous and submucous tissues surrounding the urethra were much thickened and indurated by a deposit of fibrous tissue without any discoverable local cause. Stricture of the female urethra is an exceeding uncommon condition, and the literature of the subject is not extensive.

The causes of stricture of the female urethra may be the same as in the male. In young and middle-aged subjects gonorrhœa, the cicatrization of chancroids, injury from child-bearing are the chief factors at work in the production of the condition. In old women induration and thickening of the urethra-vaginal cellular tissue may cause a stenosis of the canal. The case reported by Dr. Ashby seemed to belong to the latter class, although the age of this patient was only forty years.—*Maryland Med Jour.*, April 16, 1887.

Dr. Herman recently read a paper on the subject. He had measured the female

urethra in fifty-five cases in which no urinary trouble was complained of. He found that in the majority a No. 17 catheter would pass, and, in all but two, a No. 14. He related six cases of stricture of the female urethra under his own care. He had collected and arranged in tabular form twenty-three others, which were all that he had been able to find reported. He drew a parallel between the two sexes as to the etiology of urethral stricture, and showed that while it was much commoner in males, its causes were much the same in the two sexes. In both it might be the result of injury (these cases being proportionately commoner in women on account of child-bearing), or of the cicatrization of chancres. In the woman it was sometimes due to so-called lupus of the vulva. In both sexes the chief cause in young and middle-aged subjects was gonorrhœa. In the aged of the male sex, enlargement of the prostate was the common form of stricture. In old women there was found stricture due to general fibrous thickening and induration of the urethra occurring without any history of gonorrhœa, or other discoverable local cause. The author suggested that as in women the homologue of the prostate gland was the urethro-vaginal cellular tissue, these cases were possibly analogous to enlarged prostate in the male. As to treatment, he found that rapid dilatation was so simple and successful, that it was preferable to any other method.—*Br. Med. Jour.*, Jan. 22, 1887.

Sheild (A. M.), on a Remarkable Case of Primary Syphilis.—A respectable single woman, aged thirty-two, came to me on December 1st. She was well nourished. On the right cheek, just above the angle of the mouth, was a round prominent sessile growth about the size of a florin. It was livid in color, quite devoid of pigmentary change, and irregularly excavated in the centre by superficial ulceration. A thin non-purulent discharge exuded from the ulcerated surface. The growth infiltrated the tissues of the cheek, but not with the hardness of cancer. The submaxillary lymphatic glands were greatly enlarged, forming a series of manifest almond-shaped swellings, which reached from the angle of the jaw to the symphysis. They were not painful or inflamed, and, though firm in consistence, lacked hardness and fixation. There was no sore throat, or any sign of eruption on the skin.

Towards the end of September, 1886, she observed a small pimple on the cheek, like a "gnat-bite." She picked it frequently, causing it to bleed. About the middle of October, her mistress remarked on its appearance, so she concealed it with sticking-plaster. By the end of October, the sore was as large as her "finger-nail." She now sought the advice of a chemist, who twice applied "strong caustics." After this treatment it became very painful, and increased greatly in size. The opinion of medical men was now sought. Some said the growth was "lupus," others pronounced it to be cancer, and nitric acid was freely applied; but the growth continued to increase. Taking all the circumstances of the case into consideration, the woman was at once placed upon full doses of mercury, and a very dilute mercurial ointment was applied to the sore.

On December 8th, exuberant granulations had spread round superficially, causing the mushroom-like appearance familiar in malignant growths.

On December 15th, the sore was better, and there was a decided syphilitic eruption over the body and neck, which the patient noticed first on December 10th. The rash consisted mainly of papules and tubercles of a dark "coppery" hue, covered by slight scaly desquamation. The gums were affected by mercury.

The improvement continued, and on December 31st, the sore had nearly healed, its former site being represented by a red and depressed scar, covered in the centre by a dark scab. The eruption on the skin was nearly gone. There were some white mucous plaques on the under surface of the tongue. The throat was congested.—

Br. Med. Jour., Feb. 5, 1887.

Cant (W. E.) on "Induration" in the Primary Lesion of Syphilis in Women.—The following results were founded on about 3,300 cases examined in the Royal Albert Hospital, Devonport, during a period of six and a half years. In contradistinction to the generally accepted fact that in men induration is as a rule well marked, it is so in women far less generally. The induration, which is described as being circumscribed, limited to the base of the sore, and clearly marked off from the surrounding tissue in men, in women is, about as often as not, diffused a considerable distance into the tissues around, often very widely, not sharply defined from

the surrounding tissues, nor circumscribed in the base of the sore itself. The most typical form of primary sore with its induration, resembling a disc of cartilage set in surrounding soft structures, described as being frequent in men, is seldom met with in women. Every variety as to the degree of development of the induration is met with in women; but there is a large proportion in which it is very slight (about one third). In some of these slight cases it is impossible to affirm that there is any thickening at all present, and there is a small number in which none exists throughout the whole course of the sore. Induration is present in the early stage of the sore only in a small proportion of cases. The time of its occurrence in the course of the sore varies greatly; it may occur at almost any period of its course. It becomes most marked and developed towards the middle and latter part in many cases.—*Lancet*, Feb. 12, 1887.

Mitchell (H.) on Primary Hunterian Chancre of the Cheek.—Early in December last a soldier twenty years of age was admitted into hospital with an ulcer in the middle of the right cheek. In character this ulcer was circular, about the size of a sixpence, shallow, clean cut, but the edges not undermined; the surface had a glazed appearance, and secreted a very little watery discharge; its base was surrounded by slightly indurated tissue, which was somewhat inflamed. At the angle of the jaw on the same side was an enlarged gland, not inflamed, about the size of a bean. As the situation of the ulcer corresponded with the position of the chain of the man's helmet, it was thought probable that either the metal of the helmet chain or some substance used in cleaning it had irritated an abrasion on the cheek and so caused the ulcer. The man had no constitutional symptoms. The ulcer was considered to be a poisoned wound, and treated accordingly, first with poultices and hot fomentations, then, when the inflammation had subsided, with diluted red oxide of mercury ointment. In less than three weeks it had quite healed; the slight amount of induration at its base had disappeared; the gland, however, remaining as before, and showing no signs of inflammation. The man was about to be discharged from hospital, and was being examined as to his general condition for this purpose, when a copious rash was seen on his chest,

back, and abdomen, extending also to the arms. The rash was mainly papular, but squamous and roseolar in places, and markedly polymorphic; in appearance and color it was undoubtedly a secondary syphilitic eruption. There was no previous history of syphilis, or any appearance or traces of a sore in the usual situations, and the man stated that he had never had one.—*Lancet*, March 26, 1887.

Morrow on the Duration of the Syphilogenic Capacity in Relation to Marriage.—The following were some of the conclusions at which Dr. Morrow arrived: 1. The facts of every-day observation showed that there was nothing constant in the contagion, nothing certain in the heredity of syphilis. Men sometimes married during the full activity of secondary syphilis and did not infect their wives nor transmit the disease to their offspring. But these negative observations were entirely valueless compared with the positive. 2. The passage of syphilis from the second to the tertiary stage, based on the anatomical appearance of the lesions, did not furnish sufficient criterion of the contagiousness or non-contagiousness of these lesions. 3. Clinical experience showed that late lesions were exceptionally, but none the less certainly, the source of the contagion. 4. While in the immense majority of cases the contagiousness of syphilis and its power of transmission ceased after the third or fourth year, yet there were well-authenticated observations to prove that these qualities sometimes continued much longer, and might be manifest the fifth or sixth year or later. 5. The power of syphilitic parents to procreate diseased children might persist after the disappearance of symptoms. 6. The precise date in the evolution of the diathesis when the syphilitic organism underwent that change which marked the limit of transmissive power was not indicated with mathematical certainty. 7. The type of syphilis, the duration of its manifestations, the constitutional peculiarity of the patient, the character of the treatment, the presence or absence of certain conditions which were commonly recognized as factors in the gravity of syphilis, all exerted a modifying influence. 8. All these elements should be taken into consideration in deciding on the propriety of a syphilitic man's marrying. 9. Direct transmission from the father to the offspring, without the mother's becoming af-

fect, could be classed among established facts.—*Med. Times*, March 19, 1887.

DISEASES OF WOMEN.

Holmes (H.) on Tetanus Following Abortion.—Mrs. M. was the mother of four living children, the youngest being thirteen months old. Her last two labors were quick and easy. They were preceded by a miscarriage between the births of the second and third child. Monday morning, December 13, 1886, she had a quick miscarriage of a four months' fœtus, but the placenta had not come. It was not easy to deliver it without ether, and as the patient was averse to taking it and had ceased to flow, after losing an average amount of blood, flu. ext. ergot., 3 i., was administered.

The placenta was removed from the cervix the next forenoon, and the womb was syringed out with tepid carbolyzed water. There was no further pain or discharge, with the exception of a final fragment of placenta, Wednesday morning.

On Saturday she was so far recovered that further attendance seemed unnecessary.

The following Monday (December 20th). in the forenoon the doctor was called to see her quickly—"she could not open her mouth." Examination showed that she had developed tetanus, which grew worse in spite of treatment and proved fatal at 3 A. M., Dec. 22d.—*Boston Med. and Surg. Jour.*, March 3, 1887.

Wiglesworth (J.) on Puerperal Insanity: An Analysis of Seventy-three Cases of the Insanities of Pregnancy, Parturition, and Lactation.—We find that the insanity of pregnancy is the least frequent of the three forms of puerperal insanity, and that the disorder tends to develop in the later rather than in the earlier months of gestation; that the type of insanity is as often mania as melancholia, at least in asylum practice; that whilst the majority of the cases recover, the curability is nevertheless distinctly below that of the other forms; and that when recovery takes place the influence of parturition is seldom manifestly beneficial at first, and may even have a contrary effect.

The most salient points in connection with the insanity of parturition are—that it occurs most frequently in primiparæ, and that the immense majority of cases com-

mence within the first three weeks after parturition; that the form of mental disorder is more frequently mania than melancholia, and that the percentage of recoveries is high, amounting to about three fourths of the whole number.

We find that women in the first lactation are not specially subject to insanity, the tendency being rather the other way, but that the affection tends to commence in the earlier rather than in the later months of any given lactation; that the form of mental disorder is melancholia more frequently than mania, and that the percentage of recoveries is very high, considerably exceeding that which obtains in either of the forms of puerperal insanity previously considered.—*Tr. Liverpool Med. Instit.*, Feb. 18, 1886.

Oliver on Hernia of Ovary.—A well-developed young girl, aged sixteen, a housemaid, was brought to the infirmary complaining of a painful swelling in the right groin. Ten days previously to this, when lifting a heavy pan, she felt something crack in the lower part of her abdomen. This was followed by a feeling of sickness, but she did not vomit. The bowels had been opened daily since the commencement of the illness. On examination, a tender, roundish swelling was found in the neighborhood of Poupart's ligament on the right side, which was easily reduced. Three days after this, as the swelling had reappeared, she returned to the infirmary, having vomited a good deal. Walking was to her now a matter of great pain. She said that she suffered most pain when she lay on her left side, less when she lay on her right, but least of all when on her back. The swelling, which was about the size of a walnut, lay immediately under Poupart's ligament (right); it was soft, elastic, of firm consistence, and did not give one altogether the feeling of being intestine. It had been easily reduced in the first instance, but on now handling the swelling special notice was taken of the amount of pain which it caused, the sense of sickness complained of, the extreme pallor of the face, and the tendency to faintness. No impulse was detected in the swelling on coughing, nor in its reduction was there felt any thing like a slip or a gurgle. On examination under chloroform, an ill-defined mass could be felt behind Poupart's ligament (right), which, on being displaced, fell into the pelvis to the right of the uterus. The

uterus itself felt healthy, but to the right of it lay a round smooth mass about the size of a walnut freely movable, easily displaced in front of the uterus, and easily tilted upwards by and beyond the reach of the finger. A coil-like structure could be felt lying external to this smooth round mass as it lay in the pelvis, but whether it was a distended Fallopian tube or a portion of small intestine, it was impossible to say. The round mass was doubtless the right ovary. On the left side the ovary was felt to be about a quarter of the size of that on the right, while its Fallopian tube could be felt about the size of a quill. On one occasion after this, when the swelling reappeared in the groin, the ovary had evidently dragged down with it a portion of intestine, for in the reduction a gurgle was distinctly felt. The house-physician had a proper truss made for the patient, since wearing which the displaced right ovary, still in all probability enlarged and prolapsed, has ceased to trouble her.—*Lancet*, Feb. 12, 1887.

Elliot (J. W.) on the Treatment of Suppurating Ovarian Tumor by Drainage.—Although we know from experience in ovariectomy that patients may tolerate an extraordinary amount of damage in the way of tearing out an adherent cyst wall, we also know that patients not infrequently die on the table, or soon after these most severe operations. Drainage offers a chance for some of the bad cases. I have taken pains to follow out these cases, in order to get a clear idea of the course and results of drainage. With this side of the picture complete, we shall be better prepared to decide in a given case whether to risk a very serious operation, or to go through with the tediousness of drainage. Schroeder and others have objected to drainage, on account of the tendency to recurrence. Rheinstaedter¹ reports seven cases where more or less of the cyst was left and drained; all seven recovered without recurrence. Certainly, there has been no special tendency to recurrence in my three cases, and one was papillomatous, operated on one and a half years ago. If any of them recur in the future, I have, at least, the satisfaction of giving them a year or two of comfortable life. It may also be possible to do another operation, under conditions more favorable than the first.

¹ Zeitschrift f. Geburt. v. Gynaecol., B. X., 1884.

If the cyst is discharging into the rectum or vagina, an attempt should be made to drain in that direction. If the cyst is discharging into the intestine or bladder, it should be removed by laparotomy, and the opening into intestine or bladder closed by suture.—*Bost. Med. and Surg. Jour.*, Nov. 11, 1886.

Ashby (T. A.) on Alexander's Operation.—The round ligaments are designed to hold the uterus in its axis in the pelvis, and to draw the fundus of the organ towards the symphysis pubis. They have little if any sustaining power in preventing procidentia, except in extreme degrees of descent, where the organ has escaped external to the vulva.

Posterior displacement of the uterus can only take place when the round ligaments have been relaxed or stretched by prolonged tension.

Shortening the round ligaments is a practical method by which the uterus may be lifted into its normal axis, and be retained in position by a restoration of its normal supports.

This operation is admissible in all cases of posterior displacement where the uterus is not fixed by adhesions, but perfectly movable in the pelvis, and where other methods of support are not of service.

The operation can prove of little value in cases of procidentia, except when employed in conjunction with other methods instituted to overcome this form of displacement.

The operation can be easily performed by one who is familiar with the anatomy of the parts. It is almost devoid of danger, if ordinary safeguards are employed.

In the class of cases to which it is limited, the benefits secured are striking and important.—*Med. and Surg. Reporter*, March 5, 1887.

Phillips (J.) on the Etiology and Pathology of Hydramnios, with its Relation to Certain Fœtal Deformities.—The author concludes :

That each case of hydramnios may have several causes at work for its production, but that the majority tend to effect some change in the tension of the umbilical vein and its ramifications, or the umbilical arteries in a less degree.

That during the early part of pregnancy, the negative pressure described by Ahlfeld is a strong factor in the formation of the fluid, while later the intercellular lymphat-

ics described by Winkler, and Jungbluth's vasa propria, take an important share.

That there is certainly renal action going on during the latter half of pregnancy, if not earlier, and during that time the amniotic fluid is augmented by the periodical addition of freshly secreted urine, or its analogue in the fœtal economy.

That syphilis, in influencing the condition of the fœtal organs, has a stronger action through them than through the placenta in the production of hydramnios.

That fœtal irregularities are much commoner than is supposed ; such items as exaggerated torsion of the umbilical vein, cardiac changes, and the like, being especially liable to be overlooked.—*Edin. Med. Jour.*, April, 1887.

Hicks (J. B.) on Uterine Contractions during Pregnancy.—The paper was on the contractions of the uterus during the whole of pregnancy, and their value in the diagnosis of pregnancy both normal and abnormal, embodying his original researches first brought before the profession fifteen years ago. He showed : 1. That, during the whole of pregnancy, alternate contractions and relaxations of the uterus occurred at intervals of varying length (generally five to twenty minutes), each contraction lasting three to five minutes. 2. That if we place the examining hand on the uterus during the contraction, it will be found firm and pear-shaped, and the fœtal parts not readily, if at all, detectable ; but if we place our hand on during the state of rest, the outline of the uterus is scarcely to be felt, whereas the fœtus can be more or less clearly made out, and can be pressed by the fingers of the hand outside into various positions, even as early as the fifth month. 3. By noting these facts, we are enabled with ease to diagnose the existence of normal pregnancy, and to distinguish between it and abnormal uterine and other tumors, such as fibroma, extra-uterine pregnancy, ovarian tumor, distended bladder, etc., and have a most valuable aid in our practice.—*Br. Med. Jour.*, March 19, 1887.

A New Uterine Tenaculum.—Dr. Hanks has had constructed a new improved tenaculum that is of the ordinary shape and size, but differs from other instruments of the kind in this respect : The steel shank is so constructed that the steel extends along the back of the handle, on the side opposite to the point, or hook.

When the latter is buried in the tissues, the direction in which it pointed is always indicated by the metal back, as in the case of Simpson's sound, so that the hook can be disengaged immediately.—*Am. Jour. Obst.*, Feb., 1887.

DISEASES OF THE SKIN.

Recently Published Cases of Dermatitis.—In a recent number of the *Boston Medical and Surgical Journal*,¹ Dr. James S. Howe reports four cases of dermatitis produced by handling our common white weed or field daisy (*Leucanthemum vulgare*).

The observations of the author lead him to suppose that it will prove harmful only to those who have a decided susceptibility to the poisonous effects of other plants. He has yet to see a single case where the patient has not already had one or more attacks of dermatitis, caused by some of the well-known plants which produce the same results as the daisy. The symptoms of the disease cannot be better portrayed than by quoting freely the author's first recorded case.

The patient was a girl of six. She was playing on the floor, minus her shoes and stockings, when the flowers were given to her; and remained there for half an hour, holding them in her lap and playing with them, as any child naturally would. The following morning her feet, legs, genitals, hands, and face were the seat of a severe dermatitis, with marked oedema of the legs below the knees, and also of the genitals. When seen late in the afternoon, vesicles of small size, and closely aggregated, had formed in various-sized groups and patches upon the affected parts. These were accompanied by intense pruritus, and within the next twenty-four hours nearly all the vesicles had ruptured. This was followed by a gradual subsidence of all the troublesome symptoms, and also by excessive exfoliation of the skin; and, in about ten days, all the affected surfaces had returned to a normal condition. This child had been twice before poisoned by rhus, according to the mother's statement, neither attack being very severe. In cases the author has seen earlier an erythematous and papular stage has been present.

Dr. H. N. Allen reports² a form of dermatitis following contact with a varnish made from the rhus vernix or vernicia and largely used for decorating furniture in China. The symptoms are an intense itching and burning, clouding of the mind, slight fever, anorexia, followed by the appearance of a crop of minute vesicles on a raised base. Much swelling and an erysipelatous condition ensues. Speedy relief follows the local use of an infusion from freshly made camphor-wood shavings, camphor water or spirit being useless.

Dr. Bronson has reported³ a case of dermatitis herpetiformis. The patient was a man 32 years of age, of fairly robust appearance, and with a history of good average health. Seven years before, he had had an initial lesion followed by adenopathies and some alopecia during the first year, but had had no symptoms since. Present eruption began about five years ago in the spring, and had continued almost without intermission until now. When first noticed, its efflorescences were papular and seemed to affect the sites of the hair-follicles, always occurred in groups, and were attended with itching. Latterly they have been vesicular. At present the groups are scattered over the greater part of the body and extremities, and vary in size from one and one half inch to two or three inches in diameter. They are composed of small papules (often eroded) and vesicles, some miliary and some larger in size. Occasionally, bullæ are produced as large as the little finger nail. The vesicles are usually tense and clear. In certain places, as on the thighs and buttocks, the groups are distinctly annular. In other situations, there will be merely a cluster of from three to five efflorescences. The majority of the lesions consist of papule, surmounted either by a bloody crust or a vesicle so fine as to be visible only when the part is pinched up between the thumb and finger. Many (if not all) of the lesions appear to proceed from hair-follicles. They are distributed alike over the trunk and extremities; less frequently on the face, and never on hands or feet. Has heretofore obtained marked relief from Fowler's solution of arsenic.

Very similar to which were two cases, reported by Duhring,⁴ the chief points

¹ *Jour. Cut. Genito-Urin. Dis.*, Jan., 1887.

² *Jour. Cut. and Vener. Dis.*, Nov., 1886.

³ *N. Y. Med. Jour.*, April 9, 1887.

⁴ March 10, 1887.

in which may be summarized as follows : The eruption began as a vesicular and bullous manifestation two years ago, and has persisted, with frequent exacerbations, rebellious to all remedies employed. The lesions have at all times, in a more or less marked degree, been herpetic—that is, have had certain characters in common with typical herpes. Together with the vesicles and blebs, distinct pustules have also on several occasions been present. The eruption, viewing its course as a whole, has multiform, consisting of variously sized and shaped, disseminated, and grouped vesicles, blebs, and pustules, appearing in more or less well-defined crops at irregular intervals. Itching and burning have been distressing symptoms—far more so than in cases of subacute vesicular eczema of like grade.

An unusual case of exfoliative dermatitis with bullous lesions has been recently reported by Hardaway.¹—The patient, who was confined to bed, was of about forty-five years of age, very stout, and somewhat nervous.

About the 1st of February, coming home late at night, she felt thoroughly chilled in the carriage, and went to bed feeling ill. The next day she noticed that there was a red patch at the pit of the stomach, which itched a little, and spread rapidly, the different red places that afterwards developed soon running together and leaving no healthy skin between. There was no great amount of scaling at first, but some degree of pruritus. She positively declares that there was no moisture.

When I first saw the patient, the disease had been in progress perhaps for twenty-one or twenty-two days. In three weeks the chest, abdomen, arms, back, and thighs presented the usual appearances of pityriasis rubra. There was neither moisture, crusts, nor appreciable infiltration, but the skin was shining and of a marked violaceous hue. She complained at this time of great burning and tension of the integument ; the sensation of itching had seemingly subsided. She was very nervous, and altogether wretched.

In the mornings, a handful of scales could be gathered from the sheets, but they were not so large as is usual, and were inclined to be furfuraceous. Still the desquamation was a marked feature of the at-

tack. The face was not involved, and on the legs below the knee there were at this time some uninvaded regions.

About twenty-four days from the beginning of her disease, there appeared on the thighs, abdomen, and buttocks, where the skin was highly inflamed, a number of tense bullæ, varying in size from a fingernail to a silver twenty-five-cent piece.

This new manifestation was preceded by a distinct chill, just as in pemphigus foliaceus, and was followed by a moderate elevation of temperature. The blisters did not run into each other, but kept their individual characters until punctured by the patient, which she did on account of the pain and discomfort produced by them. Their contents were clear. There were never more than a dozen bullæ out at one time, but each crop was preceded by a chill. There was no regularity about this symptom, as to the time of day of its occurrence ; but some time in the morning or some time in the afternoon the patient would observe that a crop of bullæ had supervened upon a chill. The bullæ were not grouped, but scattered irregularly over the surface.

The patient took freely of quinine, and at the end of a week the bullæ had ceased to appear.

The floors of the bullæ differed little in appearance from the surrounding inflamed skin, being perhaps a little redder and somewhat more moist at first. When the roofs of the blisters were hanging in shreds on the reddened skin, there was a certain resemblance at these points to pemphigus foliaceus.

Fox (T. C.) on Lichen Annulatus Serpiginosus (Wilson).—Many cases coming under the category of *L. annulatus* are less marked than in the typical case portrayed by Wilson ; and, in such cases, the papulated rings are the exception, and the bulk of the eruption is made up of patches indistinguishable from seborrhœa of the forehead. A gentleman, aged 28, was sent me for moderately severe seborrhœa of the scalp. On each side of the nose and on the cheek was a broad irregular band, half an inch wide, faintly reddened, not actively inflamed, covered with little adherent scales, greasy, but never weeping. This face-eruption was very chronic, and reminded one of some slight cases of lupus erythematosus, but there was no trace of scarring, and no clue to the

¹ *Jour. Cut. and Ven. Dis.*, Nov., 1886.

formation by the confluence of discs. The point of the nose was the site of a similar, though fainter, patch with plugged follicles. On the chest were similar, more or less rounded areas, but the lowest one was very significant. It was the size of half the palm, irregularly oblong, pinkish in color, with very little scaling or infiltration, and simulated a ringworm by the appearance of projection and freshness of the border, which was studded with a number of small, congested, and erected follicles. A few papules existed, also, over the surface, and it was evident that, as the patch spread, the follicles were specially involved, and, later on, the congestion mostly subsided. The scales were crowded with oil-globules and granules.

It would be easy to multiply instances of this kind, which show, I think, the occurrence of seborrhœa on the trunk, and connect it with the lichen annulatus portrayed by Wilson. I have already mentioned that the latter is frequently associated with seborrhœa of the scalp.

In conclusion, I will add that, besides papulated ringed patches and non-ringed patches without special congestion of the follicles, I have met with another variety in which a triangular area of characteristic shape on the back, was occupied almost entirely by erected follicles, and there existed only one or two little macules, and a ringed patch which gave me the clue to the nature of the disorder. — *Br. Med. Jour.* Jan. 8, 1887.

Neff (J. S.) on the Differential Diagnosis Between Psoriasis and Papulo-Squamous Syphiloderm.—The patient has a distinct history of syphilis. He shows the papulo-squamous variety of the papular syphiloderm. The earliest cutaneous eruptions in syphilis are the erythematous, the macular, and the papular. The papular form, however, may occur at almost any stage of the disease. For here we have an example at the eighth year. The most important point about the eruption which he presents, is its diagnosis from ordinary psoriasis. We have here a specific history to help us, but in many cases we are unable to obtain any record of venereal disease.

In psoriasis we have a disease in which the lesions are symmetrical. If there is a patch on one arm, we shall find one on the other in a corresponding position. This rule does not hold good in syphilitic squamous skin disease. In this patient we find

a patch above the elbow on one side, but none on the other. There are several over the deltoid on one side, and, in a somewhat similar position, one is found on the other side. There is one over one clavicle, but none on the opposite side. The body is free from the eruption. The small number and extent of the lesions in the specific as compared with the non-specific affection, is another point of importance. The outline of the patch varies; in psoriasis they take on some definite form, sometimes circinate, sometimes circular, but whatever form is assumed, the patches appearing later will present a similar type. In the specific affection the patches are nearly always circular or semicircular. The color of the eruption, too, is different in the two diseases. In psoriasis the patches are white in color, with many scales, which have a mother-of-pearl hue. In the syphilitic affection the patches are of a dingy, dirty color, and the scales are not so abundant. A point of the greatest importance in the diagnosis is, that in psoriasis we do not find the same cell infiltration as in syphilis. In the latter disease the patch extends deep down through the corium and into the subcutaneous tissue. In psoriasis we do not have this new cell infiltration. There may be a little inflammatory thickening, however, around the margins of the patch, which can be detected by passing the finger over the lesion or by grasping it between the fingers; in the one we find deep induration; in the other the lesion raised high above the level of the skin, but without the hard deep-seated base. In syphilis we find the line of demarcation between the diseased and the normal skin very sharply defined, while in psoriasis the thickening shades off more gradually into the surrounding tissue.

In non-specific psoriasis the scales are very abundant and are readily rubbed off. In the specific form they are more firmly attached, but scanty and thin. Itching is a rare occurrence in the latter affection, while it is quite common in the former, although not to any degree marked. When the scales are rubbed from the syphilitic patch, an uneven, dingy, granular surface is left; in psoriasis the color beneath the scales is of a bright red or pink.

The clinical history of the two affections is also different. Psoriasis occurs in early life while the specific disease appears after manhood. Psoriasis yields to treatment,

but is apt to return after a shorter or longer time. The syphilitic eruption does not always yield so readily, but when once removed is not apt to return.

The treatment is of an anti-syphilitic character, with appropriate local remedies. For the latter purpose, an ointment consisting of one drachm of unguentum hydrargyri nitratis, with one ounce of cosmo-line or simple cerate, often answers very well.—*Col. and Clin. Record*, Nov. 1, 1886.

PATHOLOGY.

Amidon (R. W.) on Malignant Disease of the Spine ; a Contribution to the Study of Cruveilhier's "Paraplégie Douloureuse."—After a detailed account of three unpublished cases occurring in his practice, the author, from an analysis of these and twenty-one other recorded cases, draws the following conclusions :

We may therefore conclude that malignant vertebral disease is an ailment of middle adult life, more common in men than in women ; that, while often following a malignant tumor of the breast, or occurring in a person with an hereditary taint, it frequently seems of spontaneous origin due to traumatism or strain ; that it runs a chronic course measured by months ; that its earliest and chief symptom is pain, generally dull and aching, in the spine, sharp, paroxysmal in the anterior regions of the trunk and in the extremities ; that these pains are apt to be bilateral, and in the area of distribution of certain nerves or groups of nerves (neural pains) ; that they are aggravated by movement, and are generally worse at night ; that complete motor or sensory paralysis, with disturbance of the functions of the bladder and rectum, indicates an encroachment upon the calibre of the spinal canal and consequent compression of the cord ; that spinal deformity is often present, but never marked or very angular ; that spinal tenderness is often present, sometimes acute, more often elicited by firm pressure only ; that emaciation is generally marked, and cachexia probably more often present than described ; that other symptoms depend on the implication of other organs by the disease, the œdema being due to obstruction of lymphatics or veins by the pressure of enlarged glands or tumors, the icterus and pulmonary signs

being due to the implication of the liver and lungs respectively ; that the growth is rather more apt to be cancer than sarcoma ; that the part most often attacked is the upper lumbar and lower dorsal spine ; that similar diseases of some other organ is the rule, the liver being most frequently the one involved ; that the immediate cause of death is generally exhaustion.

Malignant disease of the spine is most apt to be confounded with acute spinal caries. To aid in the differential diagnosis, the following distinguishing features are appended :

	Caries.	Malignant Disease.
Age	A disease of youth.	A disease of adults.
Antecedents . .	Tubercular.	Malignant.
Local tenderness and pain . .	Rare.	Common.
Neural pains . .	Later.	Earlier.
Deformity . . .	More frequent and angular.	Not always present, and seldom angular.
Anæmia	A late symptom.	An early symptom.
Emaciation . . .	A late symptom.	An early symptom.
Cachexia	If present, a very late symptom.	An early and constant symptom.
œdema	Rare; if present, anæmic or renal.	Frequent, and from obstruction.
Enlarged glands .	Rare, and if present, general.	Common and localized.
Abscesses	Present.	Absent.
Temperature . .	Hectic.	Seldom elevated.
Location of disease . .	In a large proportion dorsal.	In a large proportion lumbar.
Other organs involved . .	If any, general tuberculosis, with predilection for the nervous system or the lungs.	All organs, most often the liver.

True paraplegia, when it occurs, of course due to compression myelitis, and the same in both.

From an ordinary lumbago the pains of malignant disease ought to be distinguished by chronicity and rebelliousness to treatment. A severe lumbago lasting several weeks, defying treatment, and lacking renal characteristics, should excite suspicion of organic spinal disease.

From ordinary sciatica the pains differ by their chronicity and rebelliousness to treatment, and the fact that they are generally bilateral and often accompanied by pains in the distribution of the crural, lumbar, or dorsal nerves ; a double sciatica or continuous bilateral pains should always put one on his guard. Moreover, general weakness of the legs rarely occurs with sciatica. In spinal irritation, spinal tenderness is more apt to be general and exquisite, while the pains of that disease are fugitive, non-neural, and shifting. The history of the patient ought to have much weight in this case. Spinal irritation in

adult males is rare. The protean manifestations of hysteria should not mislead a careful clinician in the face of the unmistakable signs of organic disease generally present. Spinal meningitis and pachymeningitis are comparatively rare ailments, and are generally characterized by *non*-neural pains and various spasmodic disturbances peculiar to themselves. Intra-spinal growths cause symptoms very closely resembling those of the late stage of vertebral disease, but the early appearance and rapid progression of paraplegic symptoms, and the absence of a previous protracted stage of neural pains *without* paraplegia, are suggestive factors in the diagnosis.

The history of the case, aside from the absence of ataxia, diminished reflexes, anæsthesias, retarded sensations, and periods of complete freedom from pain, should render a confusion of vertebral disease with posterior spinal sclerosis wellnigh impossible.

Inflammatory affections of the cord *per se*, forming the various types of myelitis, should be easily recognized by their almost universal freedom from *acute* pain, and by the early supervention of real motor and sensory paralyses, and the frequency of vesical and rectal disturbances.—*N. Y. Med. Jour.*, Feb. 26, 1887.

MISCELLANEOUS.

Dr. Daniel G. Brinton, who has been for a number of years editor and publisher of the *Medical and Surgical Reporter*, and the *Quarterly Compendium of Medical Science*, begs to inform his many professional friends and the medical public in general, that he severed his connection with those journals on the 1st of May, 1887. He felt obliged to take this step by the opposition of the parties who own those journals to certain changes in the *Reporter* which Dr. Brinton considered necessary improvements, and justly due in a five-dollar journal to subscribers and advertisers. The requisite authority to make these having been refused, he could not conscientiously continue to publish it at that price.

It is not his intention to retire from the arena of medical journalism; on the contrary, he hopes in the early autumn to announce his connection with a journal which will fully meet the legitimate demands of the medical public of the day.

Dr. Henry Leffmann, editor of *The Polyclinic* (P. O. Box 791, Philadelphia), desires to obtain results of the new treatment of pulmonary consumption and phthisis by gaseous enemata, *for publication in The Polyclinic*. The correct therapeutic value of this method can only be arrived at by the collection of statistics, and he therefore requests any one who has administered the gas to communicate the result to him, the formula used, and any special information that may be useful.

BOOK NOTICE.

Die Therapie der Chronischen Lungen Schwindsucht.—Von Dr. Hermann Brehmer, Dirigirender Arzt der Heilenanstalt für Lungenkranke in Görbersdorf.

The first part of the work comprises a consideration of the germ theory of phthisis, and the deduced prophylaxis and therapy.

In the second part, the author gives his own views. Phthisis results from diminished cardiac, as compared with pulmonary development. He is inclined to think that the bacilli are formed at the diseased point, from the blood corpuscles. He advocates the treatment of phthisis in special institutions, in non-phthisical districts. In his experience these are mountainous districts, of primary formation. The elevation exerts a beneficial influence on the circulatory system, and one of the main features of his treatment is to strengthen the heart, and prevent cardiac overwork. From the first, the patient is to be under the care of a physician. Great attention is paid to minute detail, both in the location and appointments of the institution, and in the diet and treatment of the patients, and for this reason especially the work is worthy of a careful perusal.

PUBLISHERS' NOTES.

Lactopeptine.—

ST. LOUIS, MO.

I have used Lactopeptine extensively in my practice during the last three years, in many cases of deranged digestion, in cholera infantum, vomiting in pregnancy, etc. I has never disappointed me. Lactopeptine, in my hands, has proved itself a desirable and useful remedy, and I have no hesitancy in recommending it to my professional brethren.

J. K. BAUDUY, M.D.,
Physician to St. Vincent's Insane Asylum, and
Professor of Nervous Diseases and Clinical
Medicine, Missouri Medical College.

Horsford's Acid Phosphates.—No difference of opinion exists among high medical authorities as to the value of phosphoric acid and the phosphates, and no preparation has ever been offered that more

happily meets the general want than Horsford's Acid Phosphate. It is the same acid that is found in wheat and other cereals, and is not only a medicine, but a scientific preparation which has received the sanction and commendation of leading physicians of America. Horsford's Acid Phosphate is especially recommended for dyspepsia, mental and physical exhaustion, indigestion, headache, wakefulness, nervousness, impaired vitality, etc., etc. For sale by all druggists and dealers in medicine.

Lactated Food.—

3 Hampton Court Terrace,
JERSEY CITY, N. J., March 8, 1886.

WELLS & RICHARDSON CO.:

Gentlemen—I have used Lactated Food for more than a year, and can say most heartily that it is the best infants' food I know of. I put my cases of malnutrition and disturbances of the digestive tract upon it with the utmost confidence. I have long felt a debt of gratitude to you for giving the children such an article.

Yours very respectfully,
S. WELLMAN CLARK.

Acid Mannate.—I have used Acid Mannate with gratifying results in habitual constipation due to torpid liver, and in a variety of troubles where a pleasant aperient was indicated. I think it a preparation of great value. M. M. GRIFFITH, M. D.
Dubois, Pa.

Celerina.—ERNEST F. KING, M.D., 943 M Street, N. W., Washington, D. C., says: I have used Celerina with gratifying results in hysteria and overworked brain.

Colden's Liquid Beef Tonic.—Having become familiar with "Colden's Liquid Beef Tonic," I take pleasure in recommending it as an excellent preparation, combining as it does food and tonic in a remarkable way, producing good blood, health, and strength.

DR. S. W. HUNTER.

Baltimore, Md.

Murdock's Liquid Food.—Household Necessities: "Murdock's Liquid Food" may be specially mentioned. This extract has attained a high reputation in America, and from a knowledge of its use in the wasting diseases, especially of childhood, it has hardly an equal in respect of its speedy digestion and strength. In general debility this Food is of high value, and those who have cases of wasting disease

under their care should give this food a trial.—From the *London Health*.

Iron-Alum Mass.—The Seven Springs Iron-Alum Mass is the best remedy for chills and fever that I have ever found. I speak from experience as well as observation. C. O. WEBB, M. D.

Crockett, Texas.

Home for the Feeble-Minded.—The attention of our readers is called to the advertisement of Dr. Geo. Brown in this issue.

Physician's Exchange.—If you wish to sell your practice, real estate, books, instruments, etc., read the advertisement of The Physician's Medical Exchange in this number.

Milk of Magnesia.—The Charles H. Phillips Chem. Comp. Co., 30 Platt St., New York, desire to call your attention to their ad. on front page of cover. Their Milk of Magnesia should be given a fair trial in the acid diarrhoea of children, cholera infantum, vomiting in pregnancy, food souring on the stomach, or kindred ailments. It will be found a superior agent. Mention the MEDICAL ANALECTIC.

BUFFALO, N. Y., Sept. 27, 1886.

Provident Chemical Works, St. Louis, Mo.

Gentlemen:—Some time ago you very kindly sent me a box of your crystalline phosphate.

I have not had opportunity heretofore to give you expression of opinion regarding it. Now that I have given it a fair trial, it gives me great pleasure to say that it certainly is a most excellent preparation, and one of undoubted value in the class of diseases for which it was and is intended.

Very truly yours,
C. T. WOLSEY, M. D.

261 Seneca St., Buffalo.

McArthur's Hypophosphites.—We desire to call your attention to Dr. McArthur's chemically pure Hypophosphites. Physicians should send for formula and testimonials. See advertisement on another page.

Summer Home for Invalids.—The Medical and Surgical Sanitarium at Battle Creek, Mich., is said to be the largest sanitarium in the world, and is certainly one of the most complete in its appointments, and should you have a patient desiring quiet and rest during the summer months, send to the superintendent for full particulars, mentioning the ANALECTIC.

THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

VOL. IV., No. 6.

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WHOLE No. 42.

LEADING ARTICLES.

Grigorescu (G.) on Bovine Impaludism and Hemoglobinuria.—In Roumania, an eminently malarial country, there have for a long time been outbreaks of an epizootic malady which has decimated flocks of horned cattle. Local veterinarians have called it gastro-entero-nephritis, an inflammatory affection.

It is an adynamic disease marked by inertia, depression, complete anorexia, and hanging of the head. There is very high fever, and petechiæ are visible upon the sclerotic, buccal surfaces and in all regions where the skin is thin. The urine is sp. gr. 1009, acid and red, greenish by refracted, yellowish by reflected, light. It has an abundant sediment, like the lees of wine, which boiling increases. The sediment dissolves completely with heat and acetic acid, is granular under the microscope, and proved by chemical examination to be hemoglobin. Under the microscope the red corpuscles are crenated, variable in size, and contain black granules in their centre. There are 2,000,000 red corpuscles to a cubic millimetre of blood where there should be 2,800,000 or more. The leucocytes are abnormally abundant.

On autopsy innumerable petechiæ are found on the inner surface of the skin. The muscles are pale. The connective-tissue in general is infiltrated with clear serum. The mucus and serous membranes are studded with bluish or blackish petechiæ.

The endocardium is of a uniform brown. Serous cavities contain small quantities of limpid serum. The lungs show hypostatic congestions. The liver is pale; the bile very thick; the spleen four or five times its normal size, and soft. The kidneys are very red and have petechiæ between the pyramids. The blood is fluid and serous,

flowing freely from all cuts, and is never coagulated.

The disease occurs principally among cattle pastured in swampy places where *Equisetum pratense* abounds, and to it has been long attributed the hematuria. The course of the disease is continuous, rapid, and shows evening exacerbations. The termination is always fatal.—*Rev. de Méd.*, Feb. 10, 1887.

Post (A.) on Deaths from Gonorrhœa.—As confined to the anterior urethra, that is, the urethra anterior to the compressor urethræ muscle, gonorrhœa is ordinarily harmless, so far as immediate danger goes; yet even here fatalities occur. Voillemier¹ reports a case:

A man with a urethritis and a very painful chordee, "broke" the chordee in true French fashion, and died of purulent infection. At four and one half centimetres from the meatus was a complete rupture of the canal, and the cavernous bodies were almost completely destroyed by suppuration.

Another case occurred in the practice of Villeneuve.² The patient was suffering from "intense chordee and continual erection, to relieve which twenty leeches were applied. Two days after a scab formed on the most prominent part of the curve; when it fell off the corpora cavernosa were exposed for a length of three or four centimetres. Rigors, pains in the joints of the upper extremities, purulent effusion into the left elbow-joint, and delirium followed, with arterial hemorrhage from the slough on the penis, which caused the patient's death. Phlebitis of the prostatic plexus, metastatic abscesses in the left lung and liver, and pus in the elbow-joint were found after death."

¹ Voillemier, p. 9, Case 8.

² *Gazette Hebdom.*, 1873, p. 210. Quoted in *Milton on Gonorrhœa*, p. 215.

When the disease extends beyond the mid-urethral sphincter, as it so often does, it opens up a field of greater danger. In the prostate the gonorrhœal inflammation may be follicular when it is one of the causes of obstinate gleet; or parenchymatous abscesses may form, which may open externally, into the rectum, or the urethra, on in any two of these three directions. When the pus is discharged through the urethra the symptoms usually vanish with great rapidity. Not unfrequently, however, according to Fournier, the suppuration from a prostatic cavity continues indefinitely and proves fatal after a long period of suffering and cachexia. Pitman reports a case in which the death was rapid.

John E., aged twenty-five, a baker, was admitted April 25th to St. George's Hospital. He had had gonorrhœa for a fortnight, with pain across the loins. Four days before admission the pain increased in severity, and extended down the legs so that he had to discontinue work. He never had any chills. On admission he had much the aspect of a fever patient. He was unable to pass urine except with the aid of a catheter. May 1st, he was delirious with involuntary evacuations. Eight days after admission he died.

Post-mortem.—The body was in good condition; there was profuse purulent discharge from the urethra which had collected about the glans penis. The right kidney was healthy, in the left the pelvis and ureter were rather more vascular than usual. Peritoneum healthy. The mucous membrane or the urethra seemed slightly injected in parts, but this appearance was so slight that little reliance could be placed upon it. The muscular fibres of the bladder seemed rather thicker than natural, but showed no trace of inflammation. Between the bladder and the rectum was a large abscess which at the time of the examination communicated with the floor of the prostatic urethra by two ragged orifices. The tissue of the prostate gland was extensively destroyed and eroded by the abscess, and on squeezing the abscess, pus could be made to exude by the prostatic ducts; but in parts near the abscess the tissue of the prostate seemed healthy. The cellular tissue in the neighborhood of the abscess was condensed; in other parts of the pelvis it was healthy.

The account allows us to wonder whether the abscess might not have been due to

punctures from the catheter. Be that as it may, the dependence of death upon the gonorrhœa would be undisputed.

In these cases the suppuration itself itself seems to have been directly the cause of the fatality. It is more often the cause which sets in action some secondary cause. In the *Annales des Maladies des Organes Génito-Urinaires* (vol. ii., No. 9), is a case in which the abscess of the prostate was followed by pyæmia. A man had had four years previous his first gonorrhœa, which lasted six or seven weeks. Two months previous to the date of narration he contracted a second, which was nearly well when retention of urine appeared. Catheterism was performed, with the effect of causing marked bleeding, which continued at intervals for three or four days, until his entrance to the Hospital Neckar, under the care of Geyon, where he died shortly, with partial suppression, albuminuria, and uræmia. Autopsy showed the prostate to be the seat of a parenchymatous abscess, which was the cause of the retention, and the posterior urethra was torn by the point of the catheter. The bladder showed, in the vicinity of the neck and the trigone, very marked inflammatory alterations; the right ureter was dilated and corresponding kidney was intensely congested. There were metastatic abscesses in the lungs, the liver, and other organs.

Lallemand gives a case of a man who had frequent attacks of gonorrhœa, and died with an abscess of the prostate, and pyelo-nephritis.

Occasionally gonorrhœal cystitis is succeeded by pyelitis, the inflammation creeping up one or both of the ureters to involve the kidneys. This process is recognized more frequently since infection from external sources has come to play so great a rôle in surgical pathology.

Murchison reports the following cases: Stephen H., aged twenty-eight, a grocer's assistant, was admitted to the London Fever Hospital on June 4, 1885, in a state of profound coma, with low muttering delirium and dry brown tongue. Three hours after admission he died, having had several attacks of general convulsions. The symptoms obtained were of little value. After his death it was ascertained that he had been suffering for some time from gonorrhœa, for which he had been taking copaiba, and that the cerebral symptoms had come on suddenly only thirty hours

before admission. In fact, he had gone to his employment on the morning of the day before admission into hospital.

After death the entire length of the urinary passage, from the anterior end of the urethra to the pelves of the kidneys, was found to be in a state of intense inflammation, the mucous membrane being tightly injected and its surface bathed with pus. Both ureters were full of thick, yellow pus. The kidneys were much enlarged, but their outer surface was quite smooth; they were of a deep purple almost black hue, and a quantity of dark blood dripped from their cut surface.

Marie D., was admitted into the London Fever Hospital on January 31, 1866, quite unconscious; her breathing became stertorous, the stupor more profound, and she died February 2d.

After death it was ascertained that she had appeared well during the day before admission, having travelled on that day from Paris with the cook, who served in the same family. On reaching London in the evening she ate a good meal, but during the night she wandered a good deal, and on the morning of January 31st she had a convulsive fit followed by unconsciousness.

At the post-mortem the membranes and substance of the brain were found to be intensely hyperæmic, but there was no exudation of lymph and no sign of tubercle within the cranium or lungs.

Both kidneys were in the early stages of acute nephritis, large, smooth, and almost black from intense congestion. The ureters and the pelves of the kidneys were full of thick yellow pus; the bladder also contained pus. The lining membrane of the vagina, the urethra, bladder, ureters, and pelves was intensely red.¹

Delafield has seen one similar case. The patient was a prostitute who came into the hospital with specific (that is, gonorrhœal) vaginitis. After a few days she developed symptoms of an acute cystitis; after a few more days she was attacked with rigors and a febrile movement, passed rapidly into the typhoid condition, and died. At the autopsy there were found acute cystitis, pyelitis, and numerous small abscesses in both kidneys.

At the discussion on Murchison's cases Greenhow mentioned a similar case which

he saw when he was a student at Edinburgh. A man died in a state of coma of thirty-six hours' duration. He was supposed to have been poisoned, but was the subject of gonorrhœa, for which he had been taking copaiba and using injections. Newbiggin attributed the death to cerebral metastasis from gonorrhœa checked by treatment.

In the summer of 1885 I was asked to examine for stone the bladder of a young boy suffering from cystitis; he denied gonorrhœal antecedents, and his history as given warranted a suspicion of calculus. The examination was made. It was followed by an exacerbation of symptoms, and a pyelitis became evident.

After some months of suffering the boy died, evidently of pyelitis, though no autopsy was obtained. During his sickness a more rigid cross-examination elicited the fact that the cystitis was gonorrhœal. Of course the examination ought not to have been made, the history of gonorrhœa ought to have been learned at first. I am not sure that the disease had not already extended up the ureters when the examination was made, but the increase in severity of symptoms followed very closely on the examination, and the case may well stand as an illustration of the impropriety of meddling recklessly with an inflamed bladder. The ease with which such an error may occur, was illustrated within a very few days. A little boy of thirteen was referred to me at the City Hospital, for examination for stone, by a gentleman whose diagnostic ability in urinary cases is well recognized. The boy complained of pain at the end of micturition, and the occasional passage of blood in small amounts. He was under-sized, and looked much less than his years. The house-surgeons recognized him as a recent victim of gonorrhœa, and a more careful review of the case established the diagnosis of gonorrhœal cystitis.

Peritonitis and subperitoneal phlegmon ought to be joined to the number of possible complications of gonorrhœa.² These accidents are the remote effects of gonorrhœal inflammation propagated from the urethra to the peritoneum or to the subperitoneal cellular tissue, through the intervention of the deferent canal, the vesiculæ

¹ Clin. Soc. Trans., vol. ix., 1876.

² Faucon. De la péritonite et du phlegmon sous-

péritonéal, d'origine blennorrhagique. *Arch. Gen. de Méd.*, 1887, vol. ii., pages 345 et 386.

seminales, the prostate, perhaps from the bladder, the ureters, or the kidneys, and from the cellular atmosphere which surrounds them, so that gonorrhœal peritonitis may begin at various points in the pelvic region, at the recto-vesical cul-de-sac, at other times from the internal orifice of the inguinal canal, and will always be preceded by more ordinary complications. Peritonitis, after inflammation of the cord, was observed by Hunter, and Ricord is said by Fournier¹ to have observed it many times. Ricord is also reported by the same authority to have seen two cases in which gonorrhœal inflammation of the prostate was propagated to the peritoneum, causing at first a pelvic peritonitis which became general and terminated fatally.²

The following case is interesting as bearing upon the subject under consideration, and also from the distinguished names attached to it :

L. L., aged sixteen, entered the Hospital la Charité June 4, 1856, in the service of Velpeau, for a left blennorrhagic epididymitis. The gonorrhœa had lasted fifteen days and the epididymitis five days. The epididymitis proceeded rapidly towards resolution and the discharge had ceased when the patient was taken with chills and general malaise and vomiting. On the 17th the patient was transferred to the medical service of Cruveilhier, and on the 21st he died of peritonitis. The autopsy showed a generalized peritonitis. Pus exuded from the prostate. The left vesicula seminalis contained a small quantity of purulent liquid. That vesicula was larger than the right, and the cellular tissue which surrounded it was very injected and thickened. The deferent canal was greatly injected, as well as the surrounding cellular tissue, and it adhered closely to the peritoneum which covered it. The peritonitis had started from the recto-vesical cul-de-sac.

It does not seem very hazardous to say that some, at least, of the cases of peritonitis in the male, of unknown or supposed idiopathic origin may have arisen from gonorrhœa, in one of the many ways mentioned.

Gonorrhœal rheumatism opens up a long list of serious cases, though fatal cases are uncommon. But a short time ago the comparative table of the symptoms of gonor-

rhœal and ordinary acute rheumatism, which is almost inseparable from an account of gonorrhœal rheumatism, used to specify that gonorrhœal rheumatism did not attack the heart. That is no longer considered a characteristic of the gonorrhœal disease. In 1854, Brandes, of Copenhagen, reported a case of endocarditis, and at least sixteen cases had been reported up to 1883, the date of Milton's book, in which the cases are collated. Of these, two were fatal. One is given by Tixier from the practice of Lorain. "There was cardiac complication with bellows sound; also disturbance of circulation, succeeded by signs of mitral insufficiency, with considerable hypertrophy, all following upon blennorrhagia with rheumatic pain. Later on came asystolism succeeded by death from cardiac disease."³

In 1833, Stanley published the paper on "Irritation of the Spinal Cord and its Nerves, in Connection with Disease of the Kidneys," on which was founded the theory of a reflex urinary paralysis. In that paper were narrated two cases in which complete motor paralysis involving the lower extremities and the sphincter, together with loss of sensation, ensued upon gonorrhœa; one was fatal in sixteen hours, the other in about a fortnight with sloughing.

Many other instances of supposed reflex paraplegia following upon gonorrhœa, some of which have ended fatally and some in recovery, are scattered through medical literature. Gull has shown that these cases of supposed reflex paralysis from gonorrhœa really depend upon distinct inflammatory changes in the cord, appreciable with the microscope, and that these changes are produced by means of an infection whether purulent or specific. Two of Gull's cases are as follows.⁴

The patient contracted gonorrhœa eight months previous. On January 18, 1855, he thinks he slept in a damp bed and three days afterwards began to have pain and weakness in the legs, and about the neck and occiput. On the 26th, he had a rigor, and the weakness of the legs was rather suddenly increased with loss of sensation about the ankles, and formication. Incontinence of urine came on at the same time with bed-sores, frequent involuntary spasms of both legs, etc. He died rather

¹ Nou. Dict., v., p. 214.

² Nou. Dict., v., p. 203.

³ Milton on Gonorrhœa, p. 316.

⁴ Medico-Chirurg Trans., t. xxxix., p. 200. 1856.

suddenly May 16th, four months from the beginning of his symptoms. To the naked eye the cord showed no changes, but extensive disorganization was evident, was shown by the microscope.

Henry F., aged twenty-one, had gonorrhœa many times and a permanent gleet. He was quite well on Tuesday morning, March 1 1853. In the afternoon he began to have pain between the shoulders, and diarrhœa. Pain in the back increased during the night and spasmodic tremblings in the legs. On March 4th, at Guy's Hospital under Cooper, the following condition was found: complete loss of motion below the sixth dorsal vertebra; the muscles of the seventh intercostal space did not act in respiration; sensation was perfect above the line indicated, but on the abdomen pricking the skin gave no pain and only the faintest sensation; in the legs there was complete anæsthesia. A fortnight later he died, exhausted by irritative fever and sloughing. The cord was generally softened as high as the middle of the dorsal region. Between the bladder and rectum there was an irregular abscess, with sloughing walls, communicating with the bladder by a large perforation of its coats. Near the bulb was a more recent abscess filled with healthy pus.

If these two cases of Gull's stood alone, the association between gonorrhœa and the changes in the cord and death might be regarded as accidental, but they belong to a series of cases sufficiently long to be quite convincing.

We have seen pyæmia as a frequent cause of death in various complications. Sometimes, however, purulent infection takes place without other appreciable lesion than gonorrhœa itself. Milton makes an especial heading of gonorrhœal pyæmia, under which he relates two cases, one from Charteris,¹ a boy of seventeen with his third case of gonorrhœa with retention of urine for which no cause is given. He died with the usual symptoms of pyæmia and with purulent collections in both shoulder-joints. The second was a man of thirty, whose gonorrhœa had already lasted two years.

The results of stricture have been purposely omitted, as well as those numerous cases peculiar to women, in which pelvic inflammation consequent on gonorrhœa wears out the patient with months of suffering.

In these cases the ages are rarely given, but the number of times in which the victim is said to have been a boy under twenty is noticeable. I am inclined to believe that the disease is often exceedingly severe in the precocious youths who acquire it while yet in their early teens. Some of these boys are rather wanting in physical development, and some at least would be described as scrofulous—a class exceedingly prone to a severe type of urethral inflammation.

Extended travelling, as in the case of the lady's maid of Murchison's case of pyelitis, is to be feared during the acute disease. It hardly seems possible that the rapid death of that young woman could be attributed solely to her journey from Paris to London; but serious difficulties, short of death, occur often enough under similar circumstances to make a journey of any length particularly undesirable. Some of the more active occupations entail similar unpleasant consequences.

Finally, these cases serve to emphasize the fact that gonorrhœa may be an exceedingly grave disease, which does not exhaust itself in the urethra, and that its possibilities render it an object worthy of study by the conscientious student, and of honest care by the attending physician.—*Boston Med. and Surg. Jour.*, May 5, 1886.

On Two Cases of Accidental Vaccinia, One Proving Fatal.—The fatal case² observed by Jay of North Adelaide, is reported as follows:

"Mrs. R.—had two children, aged 2½ years and 8 months respectively. The younger child suffered from infantile eczema from two months old, and was off and on under my treatment during this time. The skin affection was limited to the face, ears, neck, affected the forehead slightly, and spread down the chest to the level of the third rib.

"On June 30th of this year I vaccinated with human lymph the elder child in the ordinary position, and the vesicles ran through their customary course with very little surrounding inflammation or constitutional disturbance.

"On the morning of July 20th, Mrs. R.—brought her infant to my consulting rooms, saying he had been taken ill four days previously with sickness, feverishness, restlessness, etc., and the eczema of the face had

¹ *Brit. Med. Journal*, 1876, vol. ii., p. 712.

² *Australasian Med. Gazette*, Jan., 1887.

broken out afresh; also that on the previous day, the 19th, his first tooth had come through. I looked at the child's face, I am sorry to say, in rather a hurried and careless manner. The skin presented a roseolous condition at the edges of the patches of eczema, which was dry and squamous in character on the forehead and chest, moist on the cheeks, neck, and ears, without much crusting or thick scabs. I jumped at the conclusion that the child was suffering from a recrudescence of his old complaint, aggravated by the teeth irritation, and I treated him accordingly. The child was slightly feverish and irritable, and the mother found great difficulty in keeping his hands from his face.

"Two days after this, *i. e.*, on the sixth day after the onset of the attack, I was called to see the child, and, to my astonishment, found the face and neck covered with a vesicular eruption which, I remarked to the parents at the time, closely resembled small-pox of a confluent type. Numerous isolated vesicles with commencing central depression were scattered over the forehead, on the nose and eyelids, and on either side of the patch on the chest; there were three or four vesicles on both hands, and one over left hip. The cheeks, ears, chin, front of neck, and upper and central part of chest were covered completely with a confluent mass of vesicles, which had in parts become softened and macerated by the local remedies used, which consisted of a lotion containing oxide and carbonate of zinc, glycerine and rosewater, occasional poultices, and bathing with thin gruel water. Temperature, 101 deg. Beyond the irritation caused by the rash, the child did not appear to be suffering to any great extent, although the mother informed me he had had little or no sleep for the previous three nights. I informed the parents that I had never seen a case of eczema undergoing such a change, and presenting similar characteristics, and I suggested the advisability of further advice.

Consequently, on the following day, a week after the commencement of the illness, Dr. Verco saw the case in consultation with me, and suggested what was without doubt the origin of the disease, *viz.*, that the raw eczematous surfaces of the infant's head and face had become infected with the vaccine pock on the elder child's arm. On enquiry, I found that,

contrary to custom, the two children had been allowed for several nights prior to the infant's illness, and before the elder child's vaccine vesicles were thoroughly healed, to sleep in the same bed; and it seems highly probable that it was during this time the infant became inoculated.

"The case went on quite as well as one could expect up till the fourteenth day. The temperature, which had risen as high as 102 deg., had then subsided to normal. There was a slight attack of diarrhoea lasting only one day; there was little or no inflammation surrounding the eruption. The child had taken food well up to this date, consisting mainly of mother's milk for the first few days, white of egg and brandy, and Nestle's food. After the irritation subsided, the child slept fairly well; soothing lotions had been applied, and the face dusted with a powder of zinc and starch, and poulticed. Most of the crusts about the face and mouth had by this time loosened off; the skin beneath appeared to be less affected than I had anticipated.

"The mother, who had nursed the child up to the fifth day of illness, and who had not been vaccinated since infancy, although she had one distinct vaccination mark on her arm, developed several well-marked vesicles on both nipples and breasts, one in right anterior nares, on left lower eyelid, on left cheek, and two or three on side of neck.

"These all ran through a typical course of vaccinia, and gave rise to a considerable amount of lymphatic inflammation. No others in the house were affected, although the father suffered from a sharp attack of diphtheria, commencing two or three days before the child's death. On the fourteenth day, the child for the first time seemed unable and unwilling to take any food, symptoms of collapse set in, and the mucous membranes became very blanched. I endeavored by all stimulating means to keep the child's strength up, but he gradually sank and died on the following day."

A very similar but not fatal case is reported by Mitchell in the March issue of the same journal.

"C. B., *æt.* two years, was first seen by me on August 11th. He was suffering from a vesicular rash, extending over large areas of the limbs and body. Had been vaccinated unsuccessfully when six months old, but the failure was probably due to the quality of the lymph. Ever since he was

three months old he had suffered from eczema of the face, limbs, and body in a greater or less degree. Latterly the eczema was almost entirely confined to the limbs in the neighborhood of the elbows and knees. Five or six days before I was called in, the eczematous patches began to inflame, and in a few hours distinct nodules could be felt. These gradually increased in size, and developed a vesicular character, all being in about the same stage of development. On the 11th inst., I had no difficulty in deciding as to the nature of the disease, as each pock was well shaped, and as nearly as possible mature. On the right leg the vesicles were discrete, but on the left leg they were confluent into large masses four or five inches across. Very many groups of vesicles were scattered over the body and arms, the groups containing from three to twenty marks each. Altogether I estimated the number of vesicles at about 400, every one well marked, umbilicated, mature, and of rather larger size than the ordinary vaccination pock. The constitutional disturbance in the child was not very marked. The temperature rose to 101° , and he was listless, cared little for food, and cried on being moved, in consequence of the enlarged glands in axilla and groin. Pustulation followed with no more than ordinary areolar inflammation, and the pocks faded away by about the fourth week, leaving scars in many places, but not so well marked as I had expected. The eczema is, for the time, decidedly better, but time only can show whether it will return to its former degree of intensity. I endeavored to obtain photographs of the limbs, but, owing to accident, the negatives were spoilt.

"In connection with this case it is interesting to note that on July 9th I had vaccinated the infant brother of this child, and the two children played and slept together. No other vaccinated child was near my little patient during the whole time, so that a period of eighteen days elapsed from the maturity of the infant's arm till the older child became inoculated. I not unfrequently vaccinate a child suffering from eczema, choosing a spot clear away from the eruption, and covering the marks with a wire netting to prevent auto-inoculation until after maturation of the vaccine pocks. After that time there is no danger of the eczematous surfaces taking on vaccinia, even if any lymph came in contact with them."

On Puncture of the Abdomen for Extreme Flatulent Distension in Puerperal Cases.—Priestley reports¹ the following case occurring in the practice of Surg.-Maj. Franklin in India. The patient went out to be married in India two or three years ago, and her first labor began on April 8, 1886. The presentation was natural, but after a long and tedious labor, resulting from inefficient pains, the case had to be terminated by forceps under an anæsthetic, and the perineum was ruptured. Sutures were put in the perineum, and all went well until two days later, when the patient became hysterical, and began to suffer from nausea and vomiting; at the same time the abdomen became much distended. Hypodermic injections of morphia, with the application of turpentine to the abdomen, checked the sickness, and allowed milk and lime-water to be taken for a time. Next day the abdominal distension had enormously increased, there was constant vomiting, some dyspnoea, occasional rigors, and signs of exhaustion.

The extreme abdominal distension threatened the life of his patient. He had tried all the usual remedies without effect, and so was obliged to act for himself. After consultation with a colleague, Dr. Harris, he punctured the ascending colon with a small trocar. The gas escaped with considerable force, making a whistling noise as it passed through the small cannula. With the aid of pressure the greater part of it was expelled and a binder adjusted. Immediate relief was afforded, vomiting ceased, and only slight nausea remained. She had a good night, and the next morning the temperature was normal. This first puncture was made about seventy-two hours after the birth of the child. Forty-eight hours later it was necessary to puncture the colon again, and this was followed, as after the first operation, by immediate relief to all the distressing symptoms. The second operation was followed by the giving of calomel, in doses of one-twelfth of a grain, every half hour, and continued for about sixty hours, until the bowels acted freely. The temperature rose to 102° after the second puncture, and for ten days the case continued to cause some anxiety, owing to nausea and want of sleep. After this the improvement was steady, and the patient eventually got quite well. There is

¹ *Lancet*, April 9, 1887.

no record of the temperature during the access of the illness, and nothing is said of pain or subsequent inconvenience from the abdominal punctures.

Commenting on this case, Priestley adds :

"The practice of tapping the abdomen for dangerous retention of flatus is a well-known remedy in some of the ailments of domestic animals, and more particularly the operation is said to be often practised on sheep when they have 'blown themselves,' as it is called, by having eaten too largely of a very succulent pasture, or of some herbage which is improper for them. There are various records of cases where the intestine has been punctured in the human subject for extreme distension in connection with obstruction of the bowels or hernia. For example, Wagstaffe mentions a case in the *British Medical Journal* for 1887, and Broadbent another in the same journal for 1879. Further references are to be found in "Neale's Digest"; and Mr. Bryant, in the *Medical Times and Gazette* for 1872, details a case of hernia, with intestinal distension, where punctures were made in the bowel without bad result; there was no escape of the bowel contents, and only a drop of blood. That the proceeding is ordinarily innocuous enough is proved by the fact communicated to me by Dr. Broadbent, that in one patient the bowel was tapped for flatus somewhere about twenty-eight times, without bad result. Prof. Foussagrives, in the *Gazette Hebdomadaire* for 1877, says that he has seen intestinal puncture practised by Nélaton, Blache, and Velpeau, and that 'it is a sovereign operation in some cases, and not dangerous even where there are multiple punctures.' Surgeon-Major Franklin says, in one of his letters to me, that he had some recollection of a suggestion made by Dr. Braxton Hicks concerning tapping a flatulent abdomen in puerperal cases, and Dr. Hicks tells me that, though he had suggested it as applicable under certain circumstances, he has not himself employed it. I may remark that in some forms of illness after delivery there is no doubt grave danger arising from extreme abdominal tympanites. It is even probable that with the decline of other untoward symptoms the mere continued pressure of the distended intestines may so keep up irritation of the stomach and depress the heart's action as to become itself a source of peril. In these cases puncturing the intestine where it is

most distended may afford notable relief, and experience seems to teach that it may be practised with impunity."

Dr. Robert Barnes writes¹ :

"I am sure Surgeon-Major Franklin and Dr. Priestley will be gratified to learn that this treatment is fully discussed in the 'System of Obstetric Medicine and Surgery' (vol. ii., 1885, p. 500) of myself and Dr. Fancourt Barnes in the following terms: 'The treatment of tympanites is partly operative. The distress and danger attending tympanites are due in some measure to the great pressure from distension. This impedes respiration, circulation, and other functions. If the tension could be reduced, corresponding relief might be expected. Braxton Hicks advocated abdominal puncture with this intention (Obstetrical Transactions, 1868-69), and related cases in illustration. A small exploring trocar is the best instrument. By it the intestine is pierced in three or four of the most prominent points. As Hicks says: "The pressure of the gas upon the sympathetic ganglia and nerves, and the tension of the tissues which they supply, add much to the collapse and vomiting. The least that can be claimed for the operation is that the last moments of the patient can be rendered comparatively free from suffering." We have adopted the plan, and can speak favorably of it. It must never be forgotten that tympanites is not necessarily a fatal symptom; and it may well be that relieving this symptom may conduce to recovery.'"

Dr. Stephen Nesfield² contributes the following case :

"Mrs. W— (seen Nov. 6, 1875) was confined to bed in the seventh month of pregnancy, with vomiting, dropsy, and albuminous urine (nearly one half on testing). On Oct. 5th she was prematurely confined; labor natural. Vomiting persisted after confinement, and a severe febrile state followed, with flatulent distension of the abdomen as a chief symptom. This increased during the next few days, and on the night of the 12th, the distress being so great, I punctured the bowel (Mr. E. Jackson being with me) with a fine trocar. Flatus and some yellow fluid escaped. Relief was given, and the patient, after some weeks of illness, recovered, the

¹ *Lancet*, April 16, 1887.

² *Lancet*, April 30, 1887.

albumen entirely disappearing. No inconvenience of any kind followed the operation, and the patient has enjoyed good health since. The distension returned after the operation, but was not so extreme, and the puncturing was not repeated."

[The editor has repeatedly relieved the tympanites of peritonitis by the introduction of an aspirator needle, with only the most beneficial results.]

Poore (G. V.). An Analysis of 93 Cases of Writers' Cramp and Impaired Writing Power, Making, with 75 Cases Previously Reported, a Total of 168 Cases.—The cases reported were given in the form of tables. They were arranged in three groups—namely, (1) paralytic, 13 cases (10 cerebral); (2) degenerative, 14 cases; (3) neuro-muscular, 66 cases. The cases in groups 1 and 2 were nearly all referable to well-understood pathological conditions which affected the brain or spinal cord. The author was of opinion that a not uncommon cause of impaired writing power was to be found in lesions causing slight degrees of paresis of a hemiplegic type, and that the evidence of a slight, long-antecedent, and possibly forgotten hemiplegia might have almost disappeared, except in the execution of an act such as writing, which required both delicacy and steadiness. Slight degrees of sclerosis affecting the different columns of the spinal cord might in like manner be scarcely noticeable, except in the effect which they produced on the act of writing. Of the total 168 cases of impaired writing power, about one-fourth were referred to slight central changes in the brain or cord. The remaining 117 cases (66 in the present paper and 51 in the previous paper) could not with any sufficient reason be referred to central change. They formed a group which the author called the neuro-muscular group. The objective symptoms of this group (in addition to the impaired writing power), were: 1, nerve tenderness; 2, change in the faradic irritability of some of the muscles; 3, tremors. These symptoms might occur singly or combined. Nerve tenderness occurred in 50 out of the 93 cases, and in most of these it was the median nerve which was tender. Change in muscular irritability occurred 61 times in the 93 cases. The change was generally a depression, and it occurred chiefly in those muscles which, in the act of writing, were subjected to prolonged contraction, such as

the interossei, etc. Tremor occurred in more than half the cases. Many cases were complicated by slight rheumatic conditions of some of the joints. The pathological significance of altered muscular irritability and nerve tenderness was discussed, and it was shown that these conditions occurred under such varied circumstances that alone they had little value in determining the nature of the pathological change or its seat. Both, however, might be induced by excessive muscular exertion; and the author continued to regard the depressed electric irritability as symptomatic of muscular fatigue, and was inclined to regard the nerve-tenderness as also connected with over-exertion. In the treatment of cases of impaired writing power, the first step clearly was diagnosis. For cases of the neuro-muscular group, blistering and other forms of counter-irritation, applied to the tender nerve-trunks, had proved of marked value. Good results had also been obtained from massage and other methods of improving the nutrition of the affected limb.—*Br. Med. Jour.*, April 30, 1887.

Talley (R. P.) on the Hypodermatic Use of Bimuriate of Quinine and Urea.—I treated my first case October 1, 1882. It was a boy about ten years old, who had been sick two days with intermittent malarial fever. When I first saw him I found his temperature $105\frac{1}{2}^{\circ}$, pulse 120, respiration 30 to 35, vomiting every few minutes, cold extremities, and almost complete coma, with twitching of the muscles of the right side of the whole body. Bowels had been moved several times with "Simmons' Liver Regulator," and he had had several domestic doses of blue mass and sulphate of quinine during the last two days. I gave at about 10 A.M., hypodermatically, sulph. of morphine gr. $\frac{1}{4}$, sulph. atropine gr. $\frac{1}{16}$, bimuriate of quinine, and urea gr. x. in water; $\mathbb{N}$ x. Ordered a warm sponge bath to the whole surface of the body, and for him to have all the iced lemonade he could be induced to take. At 6 P.M. temperature 102° , and a corresponding improvement in every other respect. Did not vomit after taking the hypodermatic injection—an important effect of the morphine and atropine perhaps—and had drank freely of the lemonade. He convalesced favorably and rapidly without any other drugging, and did not relapse, as is so often the case in such diseases.

Case 2. November 5, 1882, about 2

o'clock P.M., I saw Mrs I., at the request of her husband, from whom I got substantially the following history, which I regarded as about correct, inasmuch as he had about ten years' experience in a retail drug store : Patient had a chill on the 2d and 3d inst., followed by fever and sweating as in ordinary intermittent malarial fever. On the 4th inst., she seemed a little delirious, but took some nourishment in the morning as on each of the two previous days ; but early in the afternoon she fell from her seat in a spasm, and had been in a profound coma ever since, with frequent convulsive movements. The family physician was sent for and arrived soon after the spasm came on. He gave a hypodermatic injection of morphine, ordered mustard plasters to her spine, and then tried to control the convulsive movements with chloroform by inhalation.

About 8 or 9 o'clock P.M., he left her no better, instructing her husband to give her chloroform freely, and not to be afraid of it, and to let him know if she got better, and gave as his opinion that she was suffering from malarial toxæmia. But little chloroform was used. The family physician was sent for and arrived again about daylight the following morning. He in vain tried again to control the trouble with inhalations of chloroform, and about 8 or 9 o'clock A.M., left her to her fate, saying to her husband and friends that nothing more could be done for her, and that he thought she was then dying and would likely be dead within an hour. On my arrival, I found her condition about as follows :

Pulse 120, full and bounding ; respiration 25 to 30, very labored and noisy ; temperature, 106° ; eyes wide open, the pupils turned up and dilated to their fullest extent, and the conjunctivæ intensely congested. Her hips were almost enveloped in involuntary actions from her bowels and bladder ; the upper extremities more or less flexed, the lower straight, and both in a constant spasmodic condition ; the head drawn back, and to the left. The coma at this time was profound. She had not had any thing, not even water, by the mouth for about twenty-four hours, and could not then take any thing, paying no attention at all to any thing put into her mouth. I diagnosed the trouble pernicious malarial fever, with very unfavorable prognosis, and treated the case as follows :

I first had her clothes all taken off, and

her whole body well washed in tepid water, then placed in a clean bed between two open doors, with no covering except a sheet. I then gave subcutaneously sulph. of morphine, gr. $\frac{1}{4}$; sulphate of atropine, gr. $\frac{1}{16}$; bimuriate of quinine, and urea, gr. xv. in solution in water, ℥ xx. Also ordered a pint of warm water, to be slowly injected into the rectum, and to be kept in by force for one hour, about every four to six hours ; the whole body to be sponged every hour with warm water, until my return, about six o'clock P.M. Within ten minutes after the subcutaneous injection the respiration and pulse were very much improved, and she never had any more of the spasmodic movements above referred to. At 6 P.M. temperature 102°, and some improvement in all the other symptoms. I added some covering, and ordered the treatment otherwise continued, except to give her water by the mouth instead of the rectum, if at any time she could so take it, and also discontinued the warm sponging, unless the skin seemed to get hot and dry again.

Nov. 6th, 8 A.M., about as at last visit, except with the water enemas a great deal of fecal matter, with some urine, had been involuntarily discharged, and she had uttered in a sort of delirious way several indistinct words, the first attempt to speak a word in any way for over thirty-six hours. I repeated the hypodermatic injection, and ordered the other treatment continued. At 6 P.M. I found her very much improved in every respect. She had voluntarily taken plenty of water, but yet had considerable delirium. I ordered milk gruel or buttermilk as nourishment, and all the lemonade she could be induced to take as drinks.

Nov. 7th, 8 A.M.—About as at last visit, except some improvement in the delirium, but would occasionally utter the most hideous delirious screams I ever heard from any one under any circumstances, and had taken some nourishment and freely of lemonade. I repeated the hypodermatic injection, and ordered the other management continued. At 6 P.M., decidedly better in every respect.

Nov. 8th, 8 P.M.—Dismissed the case, with special instructions as to food, etc. Will note here that the temperature was never over 101° after the first day's treatment. Patient made a rapid recovery without any further drugging, and had not up to April, 1885, had another attack of malarial fever.

Case 3.—August 12, 1884, I saw a child two years old, who had been very sick for three days with remittent malarial fever. At my visit (about 3 o'clock, P.M.) it was in a deep coma, and its temperature 106°. Its family had been living in the Leon River bottom for months, and the child had several attacks of malarial fever during this time, and was then very anæmic. It had been treated—domestically—with a large quantity of sulphate of quinine and some calomel during this immediate attack, and had taken, as its father said, "a bottle of quinine in the last two or three months." For treatment I gave bimuriate of quinine and urea, gr. iv.; sulph. of morphine, gr. $\frac{1}{4}$; sulph. of atropine, gr. $\frac{1}{16}$, in solution in warm water, q. s. Then ordered a warm sponge-bath every thirty minutes until the child could swallow (if ever), and then to have all the buttermilk and lemonade it could take until it was decidedly better. Two days later I was informed that the child was still living, and that while it was better in every way, its parents wanted me to see it again. At this second visit I found the little fellow looking fearfully pale, very weak, somewhat deaf, a little fever, and poor appetite. After giving careful advice in regard to diet, etc., I gave—with doubt as to its propriety—another dose of the hypodermic injection. About four months after this I learned from the child's father that it got well right away, and had been well ever since, except that it was still "very hard of hearing," but that his other children were "chilling right along," and had been for about six months.¹

During the first two years of my experience with the hypodermic injection used in the treatment of the fever cases herein detailed, I did not produce a single abscess. Up to this time I had my solutions prepared at a drug store, but these solutions would not keep well, spoiling more or less rapidly by the development of the penicilium, and an increasing tendency with the age of the solution for the salts to precipitate, and perhaps some chemical changes also. I then carried the salts in definite quantities and made extemporaneous solutions, by adding water only sufficient with heat at about 100°. With this I evidently

produced some splendid specimens of abscess. I then changed my tactics again, and began making my extemporaneous solutions not so concentrated, say 15 grains of the salt of quinine to at least 20 minims, since which time I have not had an abscess from its use.

The important details in making a hypodermatic injection are too many to be given in a paper like this. I have for many years made hypodermatic injections as *deep* and as *slowly* and as *little at one point* as possible, for the following, as I think, very particular advantages over the usual method: 1. It gives less pain; 2. it takes effect sooner; 3. it is not so likely to produce abscess; 4. There is comparatively no danger of injecting more than a few drops directly into a blood-vessel, an accident that we all want to avoid. This fourth advantage I try to obtain by first introducing the syringe-needle as deeply as I well can; then I throw out one or two minims at different points as I very slowly and cautiously withdraw the needle.

If I am not very much deceived, this preparation of quinine, to wit, *quinia bimuriatica carbomidata*, is the best yet on record for use in *any way*, and for *any disease*, for which quinine in any form is at all useful, and for reasons apparent to any thinking medical man who is at all familiar with it. I know the great tendency in our profession to ride medical hobbies, and sometimes without reason or mercy; and I hence have had an eye to this professional weakness, and tried to avoid it in my experience with this particular remedy.—*Med. and Surg. Reporter*, May 7, 1887.

Phytolacca Decandra.—Dr. J. D. Ely, of Medina, Mich., in the issue of the *Medical Age* of Oct. 11th, recommended phytolacca in the treatment of bronchocele, and reported a case illustrating its use.

In the *Medical Age* for March 10, 1887, Dr. Ely takes issue with Dr. Buxton, of Fulton, Iowa, who, in the *Age* of November 7, 1886, questions the value of phytolacca, and essays to detract from it by ascribing the cure of the case reported principally to the tonic, dialyzed iron, prescribed in connection with it.

The fact that Dr. Buxton acknowledges that he has never had any personal experience with phytolacca should be enough to make his opinion of it count for little at this time. It is not in keeping with the

¹ A fourth case is narrated in which the fever was cured, but a deafness ensued, which Talley ascribes to the treatment. The pre-existing aural disease and the severe fever more probably caused the deafness.—EDITOR.

progressive practitioner of to-day to taboo a remedy before subjecting it to a thorough trial in practice. Dr. Ely has knowledge of cases of bronchocele cured with that agent alone, and has not such knowledge with regard to iron, or any other tonic agent, uncombined.

There are few agents in the *materia medica* that he prescribes with more confidence, or that give more prompt and satisfactory evidence of therapeutical value. It has long been a favorite remedy for subduing inflammation and preventing suppuration of the mammary gland; and so certain in its effects that it has well earned the reputation of being a specific for that troublesome condition.

It is surprising how little of the remedy is generally sufficient. He commonly prescribes:

R Tinct. aconiti rad., gtt. x.
Tinct. phytolacæ decan., gtt. xx.
Aque $\frac{3}{4}$ iv.

M. Sig. One teaspoonful every hour, and have applied to the gland equal parts of tinct. phytolacæ and water, every three hours.

Of three cases which occurred in his practice in 1885, where the gland suppurated during previous confinement, and seemed likely to again, the above had to be duplicated for one only.

It is proper to state here that phytolacca has been tested singly, and proved its efficacy in many cases of this character.

Aconite, though not always a necessary part of the treatment, is useful in allaying the febrile excitement manifested.

A young man who suffered a metastasis of mumps to the testicles, was given prompt relief and cured with prescriptions not materially different from the above, in conjunction with a bean poultice.

A case of chronic follicular pharyngitis, of the *hypertrophic variety*, which came for treatment two years ago, was cured by daily applications, to the diseased surface, with a swab, of tinct. phytolacæ two parts and water one part, the time required being about two weeks.

The writer would repeat that a tincture from the fresh roots only should be used; that made from old, dry material being comparatively worthless.

Dr. J. V. Stevens, of Prairie du Lac, Wis., in the *Med. Age* for April 11, 1887, desires to testify to the (as he believes) correct deductions of Dr. Ely. He did not use it till about two years ago, for any special

cases of the kind the doctor has called attention to. He first used it in a case of exophthalmic goitre of twelve years' standing, in which both thyroid glands were enlarged and constantly becoming larger. It was applied in full strength of the tincture. He prescribed various internal remedies as alteratives and heart tonics, etc., for some time, but finally settled upon a simple stomachic tonic containing small doses of cactus grandifolia, and one minim doses of tincture of aconite, three times a day, as recommended in Flint's "Clinical Medicine," page 236, and had the satisfaction after about nine months of nearly continuous treatment, of seeing the patient (a widow lady of about 40) restored to a very good degree of health. She then passed from his observation, but since reported herself entirely well.

In every case of goitre that has since presented itself he has first and last used the pokeroor.

He has a record of eight cases, all of which have been successfully treated, with one exception, with that remedy alone. Five were young females, from twelve to twenty-two; two were males about twenty. These cases were of more recent date, having been affected from three months to as many years. He has prescribed the remedy in 1- to 5-drop doses, one to three times a day, in conjunction with its external application, in all but three cases, which have been cured by its application to the glands alone.

The exception is a case of twenty-two years' standing; under treatment four months. The first two weeks' treatment caused a decrease in size of one half inch, but since that time it only decreased as much, or another half inch, and seems likely to prove beyond the influence of the medicine to entirely remove it. It has, however, materially lessened the sensation of constriction of the throat formerly present in this case. The patient still continues treatment, as it does not seem to cause any unpleasant symptoms, nor has it in any case.

The doctor has tried it with good results also in enlargement of other glands, particularly in the case of the cervical glands as accompaniment or sequela of scarlet-fever, in orchitis and in threatened "broken breasts"; in each case both externally and internally.

He calls attention to the fact that "scoke root" (the name that the remedy in

question bears in some localities) has long been considered a specific by dairymen and veterinarians for "caked udder" of cows. He thinks very few disappointments are in store for those who use this remedy carefully in cases of simple glandular enlargement without cystic complications.

THERAPEUTICS.

Masius on the Sulphate of Spartein.—Sparte in small doses does not change the carotid pulse in the dog. In relatively moderate doses it diminishes the excitability of the pneumogastric nerve, accelerates the pulse which becomes less full, at the same time that it suppresses periodical variations of respiration. In toxic doses it causes paralysis of the pneumogastric, asphyxia, and as a consequence of that a change in the pulse which becomes stronger, slower, and then rapidly more and more feeble, intermitting and finally failing. Blood pressure is not lowered until a short time before death. It has no effect upon the secretion of urine. In disease its influence upon the heart is as uncertain as its influence upon the renal function and upon the subjective state of the patient.—*Le Scalpel*, April 24, 1877.

Ferreira (C.) on the Hydrochlorate of Pereirine.—The author has for years used this remedy in the treatment of various malarial phenomena, particularly the intermittent fevers of Brazil. With it he has cured cases over which quinine had no control.

He gives thirty to fifty grains in two doses at intervals of a half hour.—*Bull. Gén. de Thérap.*, April 15, 1887.

Watson (J.) on the Opium Question in China.—Opium was mentioned in Chinese literature early in the eighth century; it was brought with cotton from India in the thirteenth century; and ever since it had been cultivated more or less by the Chinese, who had always smoked, not eaten it, as was done by the natives of India. The amount of opium smoked by the Chinese was inconsiderable until the development of the trade with India. Until the last ninety years the Chinese government was able to control, if not suppress, the vicious habit. It had always looked with suspicion on the cultivation of the poppy, and had earnestly tried to suppress it. The ill-effects of opium-smoking were

similar to those seen in the opium-eater, and in laudanum, morphine, chloral, or brandy drinkers. The Chinese asserted that opium-smoking was first had recourse to by sufferers from rheumatic, neuralgic, and other pains, and the depression of malaria and other ailments. It was now mainly used as a means of procuring a delightful species of intoxication. The effects of the habit were physical and moral. The opium-smoker was peculiarly liable to inflamed eyes; his appetite was irregular, and his digestion was impaired; he suffered from severe colic, and from constipation, followed by distressing diarrhœa; wasting of all the tissues took place; spermatorrhœa and loss of sexual power supervened. He neglected his family and his business, became dishonest and utterly degraded. Many in England believed that the majority of Chinese smoked opium, and that the habit was rapidly ruining the people, physically, mentally, and morally. This was now proved to be a great mistake. Sir Robert Hart, as Head of the Chinese Imperial Maritime Customs, instructed the Commissioners of Customs at the various ports on the coast and on the Yangtze to report to him the amount of foreign (that is, Indian) opium that passed through the custom-houses, and was thence distributed over the whole country. This was found to be about 100,000 chests. After studying the 20 reports from the Commissioners, Sir Robert Hart calculated that $3\frac{1}{2}$ persons in every 1,000, or, in other words, one-third of 1 per cent. of the population, smoked Indian opium. Probably not more than 100,000 chests of native opium were produced; but, supposing this amount was actually consumed, then opium enough was provided to supply another 1,000,000 smokers, which would raise the total number to 2,000,000, or, in other words, two-thirds of 1 per cent. of the population. The total amount spent by China on Indian and native opium was £25,000,000. The author had treated a considerable number of Chinese who were addicted to the use of the drug, and, so far as he could see, it did not distinctly interfere with their general health in more than 10 per cent. These were, however, in as miserable a state of mind and body as could be imagined.—*Br. Med. Jour.*, April 2, 1887.

Chaves (B.) on the Salicylate of Mercury and its Therapeutic Em-

ployment.—Mr. Delgado has, I believe, the honor of being the first person to prepare this new salt.

We proceeded to experiment with the salicylate of mercury, administering it in daily doses of 1 milligram ($\frac{1}{80}$ grain), which we gradually increased to 25 milligrams ($\frac{1}{2}$ grain), in pills made of the powder and extract of licorice. In extreme cases we have given two doses a day.

Our success exceeded our expectations, and from what I have observed I am convinced that the salicylate of mercury will become as essential to therapeutics as the iodide of potassium, calomel, and other useful medicines.

The wonderful results obtained from the employment of this mercurial salt as an internal remedy led us to experiment with its external application (from 50 centigrams to 1 gram of the salicylate of mercury to 30 grams of white vaseline). The success of this experiment was no less striking than that of the internal remedy. We effected cures of syphilitic eruptions and ulcers of a syphilitic character, which had previously been treated with little or no result with other medicines, including mercurials and iodides, such as ointments of bi-oxide of mercury and iodide of potassium.

We also employed the salicylate of mercury very successfully in urethral injections for gonorrhœa, mixing from 10 to 15 centigrams of the new salt with 200 grams of distilled rose-water, and adding sufficient carbonate of soda or potassium to cause it to dissolve.

I must not neglect to state that Dr. Neves da Rocha and Prof. Moura Brazil have employed this salt so successfully in the collyrium in purulent and even granulous conjunctivitis, as well as in other diseases of the eye, that they prefer it to any other medicine now in use.

These specialists have also been very successful in their experiments with this substance in hypodermic injections on syphilitic patients, their formula being the following: 5 centigrams of salicylate of mercury to 10 grams of distilled water, with sufficient carbonate of potassium to cause it to dissolve.

The effects of this salt are much more rapid and efficacious than any other with a mercurial or iodic base, such as proto-iodide, which is very much used here,

bi-iodide, bi-chloride, phenate, and tannate of mercury, as well as the iodides of soda and potassium. It is well received by the stomach, and we saw no instances of mercurial stomatitis, gastritis, or enteritis resulting from its use.

We have successfully employed salicylate of mercury in the treatment of several cutaneous diseases, such as *marginal eczema of Hebro*, *circinate pityriasis of Vidal*, *versicolor pityriasis*, *parasitic syphilis*, etc., and even *leprosy*, in which we used it internally and externally in connection with gynecardic acid, the active principle of the *oil of gynecordia odorata*.

In an article like this much that is interesting must necessarily be omitted, but before concluding I cannot refrain from referring to the following two cases:

The first is that of a syphilitic patient suffering from an obstinate generalized tuberculous eruption, and subject besides to violent rheumatic pains and continuous gonorrhœa.

After experimenting with all the mercurial and iodic remedies usually employed in such cases and finding them all insufficient, we succeeded in removing the facial eruption by means of the ointment of salicylate of mercury.

The second was a case of syphilitic fungus near the anus, in which it is usual in the hospitals in this city to resort to an operation with the thermo-cautery of Paquelin after giving chloroform to the patient. We, however, succeeded in destroying the fungus by means of an external application of salicylate of hydrargyrum.—*Med. and Surg. Reporter*, April 23, 1887.

Reid (J.) on Drumine.¹—In a more recent communication,² the discoverer of drumine points out the principal uses of the drug as follows:

In nasal catarrh, injected into the nostrils, it effects an immediate cure. This may, in chronic cases or otherwise, be used in solution with gr. i corrosive sublimate to the pint, and gr. vi ad $\frac{1}{2}$ i hydrochlorate of drumine. Spasmodic contractures at anus—solution locally; the same in pruritus. Facial dermatitis, with acne and itching: spermaceti $\frac{1}{2}$ i, drumine gr. x. Sciatica or lumbago: case of two years' duration, unaffected by other remedies, cured by two injections. Sprains:—Cases of sprained abdominal muscles cured speedily by free

¹ See MEDICAL ANALECTIC, Jan., 1887, p. 2.

² *Br. Med. Jour.*, March 26, 1887.

injections. Periosteal pain following fracture of the lower end of the sternum, with tenderness of two years' duration, cured by injections. Burns :—Extensive denudation of skin ; very free application to raw surfaces ; relief of pain ; no constitutional symptoms. Neuralgia :—Dropped into the eye it gave relief. Operations :—Used in probing for splinter (produced feeling of deadness) ; in probing abscess in the foot, etc. Internally :—Relieved the feeling of thirst on a scorching day, and made the tongue moist. On tongue :—One side may lose the sense of taste for quinine, the other being unaffected (repeatedly tried) ; also common sensibility destroyed.

Compared with cocaine, it does not dilate the pupil ; it does not stimulate prior to paralyzing sensation ; it produces no constitutional symptoms when applied to extensive surfaces.

Stanley found that sheep might eat it for some time without its causing death, and that, when given in poisonous doses it causes hoven. This supports my views, seeing that the sensory nerves of the gut are paralyzed, secretion as well, and so absorption is in abeyance. One cat I experimented on was paralyzed in the extremities ; but the dose was very large, and a spirituous solution was used. The stomach, etc., in a cat that had tasted neither food nor water for nine days was natural and free from inflammation, etc ; the blood was natural ; the bowels were empty. I have written quite fully enough to show (1) that the drug is a pure anæsthetic ; (2) that it is safe ; and (3) that it may be used both internally and externally with advantage.

Mattison (J. B.) on Cocaine Dosage and Cocaine Addiction.—The author upon data derived from a large personal experience and from an extended correspondence on the subject, concludes as follows :

"I think cocaine for many, notably the large and enlarging number of opium and alcohol habitues, the most fascinating and seductive, dangerous and destructive, drug extant ; and, while admitting its great value in various disordered conditions, earnestly warn all against its careless giving in these cases, and especially insist on the great danger of self-injecting, a course almost certain to entail added ill.

"To the man who has gone down under opium, and who thinks of taking to cocaine

in hope of being lifted out of the mire, I would say, 'Don't,' lest he sink deeper.

"I have yet to learn of a single instance in which such an effort reached success ; but know many cases where failure followed, or, worse, cocaine or coca-morphia addiction.

"The need of caution against free and frequent using obtains in other cases, for there may come a demand for continued taking that will not be denied.

"Cocaine can be toxic, sometimes deadly, in large doses.

"It may give rise to dangerous or even fatal symptoms in doses usually deemed safe.

"The danger, near and remote, is greatest when given under the skin.

"It may produce a diseased condition—in which the will is prostrate and the patient powerless—a true toxic neurosis, more marked and less hopeful than that from alcohol or opium.

"Such being my belief, I regard Dr. Hammond's statements mistaken, and his conclusions rash and dangerous."—*Medical Register*, March 12, 1887.

Buxton (D.) on the Physiological Action of Nitrous Oxide Gas.—The effects of nitrous oxide inhalations upon the mammalian organism are, he says, broadly speaking—(1) a condition of anæsthesia ; (2) an emotional state, provoking a sensation of exhilaration—in fact it plays the rôle of a stimulant ; (3) it gives rise to modifications of the respiratory and (4) circulatory systems ; and (5) provokes marked muscular movements, which may be classed as (a) rigidity and (b) jactitations. The anæsthesia produced by nitrous oxide is not dependent upon analgesia or loss of sensation of painful impressions of the sensory end-organs, such as that produced by cocaine, etc., or upon failure of the conducting sensory nerves, for sensation is retained until the perceptive powers themselves cease to receive ; moreover, there is immediately anterior to the loss of consciousness a hyperæsthetic stage, therefore it may be concluded that the nerve centres are acted upon. The ways by which nitrous oxide may enter the system, and is enabled to produce its special effects are—either that it gives rise to other bodies by changes in its chemical form, or by acting as an irrespirable gas and causing asphyxia, or by exercising a specific action, just as strychnine does. Dr. Frankland came to the

conclusion that nitrous oxide was not decomposed during its sojourn in the body, basing his opinion upon analyses made of the air expired by rabbits when confined in an atmosphere of mixed air and nitrous oxide. In the first stage of asphyxia, that of dyspnœa, there is an increase in the respiratory movements, both inspiratory and expiratory; in the second, a dominance of the expiratory efforts, culminating in general convulsions; in the last, exhaustion, with long-drawn inspirations, gradually dying out. The blood-pressure during the first and second stages rapidly rises. Dr. Dudley Buxton has never observed an increase in the expiratory movements when HO_2 has been administered, which are merely increased in number and depth, or expiratory convulsions, notwithstanding the gas has been pushed to its utmost limit, and from a large number of sphygmographic tracings the tension in the arteries has been lower than normal. In experiments upon dogs, Dr. Buxton found that where a trephine-hole was made through the skull, during the inhalation of gas the brain pulsations became more forcible and somewhat hurried; then the brain substance was seen to swell up, until at last it actually protruded through the aperture; whereas in a similar experiment, with the trachea occluded, the brain receded, sinking away from the opening. Other experiments showed that the heart's action was but little interfered with by nitrous oxide, even where the inhalations were pushed until respiration was interrupted; during asphyxia, on the other hand, a rapid and continuous increase in blood-pressure invariably occurred. The dose of nitrous oxide required to produce insensibility varies very considerably in different persons—a fact which supports the view that nitrous oxide exerts a specific action on the nerve centres. Dr. Buxton also discusses many other interesting points in the action of the gas, such as the occurrence of hallucinations.—*Lancet*, April 9, 1887.

On the Action of Sulphuric Ether on the Peripheral Nervous System.—The principal results of various researches, made by Hooper, Ellis, Perkins, and Bowditch, may be summarized as follows:

The ordinary effect of electrical stimulation of the recurrent laryngeal nerves of dogs is to cause constriction of the glottis, but if the animal is thoroughly etherized dilatation may be produced.

If the animal is partially etherized the effect of the stimulation will vary with the strength of the current, a weak irritation causing dilatation, and a stronger irritation causing constriction of the glottis.

The more complete the etherization the greater is the intensity of the current necessary to produce constriction.

A similar "ether effect" may be observed when the sciatic nerve of the frog is stimulated, the ordinary extension of the leg and abduction of the toes giving place, under the influence of this drug, to flexion and abduction. It is, however, always possible to produce the ordinary effects by increasing the intensity of the stimulation; and, on the other hand, it is possible, by using very feeble stimuli, to produce without etherization the same effects which occur on the application of stronger stimuli to animals under the influence of the drug.

This "ether effect" on frogs may be observed both when the ether solution is introduced by cutaneous absorption and when it is applied locally to the nerve below the point of stimulation. Hence the most reasonable explanation of the phenomenon is that the drug, by diminishing the conducting power of the nerve, causes a strong irritation applied to the nerve to become a weak irritation when it reaches the muscles.

This explanation cannot be applied to the phenomenon as exhibited by the recurrent laryngeal nerve of the dog; for without ether feeble irritations do not produce dilatation, and, with complete etherization, strong stimuli do not produce constriction of the glottis.—*Am. Jour. Med. Sci.*, April, 1887.

Park (W. E.) on the Physiological Action of the Valerianate of Ammonium on the Nervous System.—With the exception of the convulsions, the drug is a universal depressant to the nervous system. The convulsions are of spinal origin. In small doses the drug probably stimulates the cord. In large doses the drug depresses the cord. Locally the drug is a universal depressant.—*Therap. Gaz.*, March, 1887.

Dercum (F. X.) on a Case of Tic Douloureux of Twelve Years' Standing, Treated by Large Doses of the Salicylates with Marked Success.—The pain was excruciating, located principally in the right superior maxillary region, had lasted twelve years, and had re-

belled against all treatment. The doctor says :

"On December 26th I saw her again, and now replaced the oil of gaulteria by salicylate of sodium, of which I gave twenty grains every four hours. This she tolerated well. Every trace of *tic douloureux* now disappeared. She voluntarily increased the dose of the salicylate to thirty grains, thus taking one hundred and twenty grains a day. Her fear of a return of her terrible affliction caused her to persist in this excessive dose until December 29th, when, upon my urgent advice, she diminished the dose to twenty grains three times a day. The large doses had caused marked depression, her tinnitus was excessive, she was decidedly deaf, and I fancied that her pulse was weak. Besides, she was taking very little food, and her digestion was much impaired. Although she had not the slightest return of pain at any time, she persisted in the use of the salicylate until January 12th, when it was finally abandoned."—*Phil. Med. Times*, April 16, 1887.

Holt (R. C.) on Iodoform-Inunction in Meningitis.—In 1885 Dr. Emil Nilsson, a Swedish physician, described a case presenting all the symptoms of tuberculous meningitis, which he had treated successfully by rubbing the shaven scalp with an ointment containing ten per cent. of iodoform. The patient was a boy of eight, whose mother had a family history of phthisis, and four of whose brothers and sisters had died of tuberculous meningitis. The symptoms in the child's case were similar to theirs—headache, torpor, convulsions, strabismus, pyrexia. Our means of treating such cases are any thing but satisfactory, and it therefore appeared worth while to investigate for one's self the value of the new method. The following cases will indicate with what success it has been applied.

CASE 1.—Female infant *æt.* eight months ; seen first on September 28, 1886, with signs of incipient meningitis, to wit, vomiting, constipation, sleeplessness, crossness. It uttered short, sharp shrieks as if attacked by sudden pain ; it had lost its usual playfulness, and seemed in constant agony ; the face wore an anxious expression, eyes staring, face paler than usual ; temperature and pulse normal ; breathing normal, but it had a cough, and *râles* could be heard in the chest. At first it was treated with belladonna (five-minim doses of tincture every

four hours). Oct. 4th—Called in the night, as the child seemed in very much pain ; it was screaming and throwing its head from side to side. No other worse symptom except that the temperature was 102°. Under the influence of chloral and a calomel powder the severe symptoms abated somewhat, but the child did not improve in general. The mother told me that it occasionally squinted and looked fixedly before it, and after doing so for some little time would suddenly scream for several minutes ; she also called my attention to the occasional appearance of a red spot about the size of a half-crown on the right temple, and at these times the symptoms were aggravated. On October 9th an iodoform ointment (1 in 4 of vaseline) was ordered to be rubbed on the head, the instructions being to keep the head constantly soaking in it. After application for a few days the symptoms gradually abated, and by October 20th natural sleep was restored, and the infant appeared almost well. It is still alive and well. One remarkable fact was that after a few applications the child indicated its want of the ointment by looking and pointing to the place where it was kept, and directly after the application was quiet and slept. This is a case in which one could not be sure of the existence of the tuberculous meningitis. The family history was good, with the exception that one child died suddenly in an unexplained manner at the age of two years and three months. My own impression was that the meningitis was tuberculous.

CASE 2.—A boy *æt.* three years seven months. I was called to this child on December 2, 1886, and found him flushed, restless, screaming fitfully, and taking no notice of any thing ; pulse 100°, temperature 102.5°, respirations increased, slight cough, *râles*, and the usual appearances of a subacute attack of bronchitis ; bowels constipated ; had vomited several times ; perspiring freely ; there was an internal squint, well marked when he was screaming ; pupils equal. The treatment of this case was not commenced for some reason unknown until the following morning, when the symptoms were worse, and he died the same evening after two convulsions. There was no post-mortem examination in this case, and the chief reason for supposing it to be a case of meningitis was the family history. The treatment in this case was the inunction of iodoform as in Case 1.

CASE 3.—A boy æt. eight months, a very fine, fat child. He seemed to droop completely as though under the influence of a narcotic, and died within three days of his seizure. The first symptoms were loss of appetite, loss of spirits, and slight bronchitis. The right eyelids swelled to the size of a hen's egg, a bright red swelling. Treatment reduced the swelling. On the second day, from the appearance of a squint and irregularity of pupils, I formed the idea that the case was one of meningitis, and ordered iodoform ointment as in Case 1. He died on third day.

CASE 4.—An infant æt. ten weeks; it commenced on December 12, 1886, to have a cough, and on the same day had a slight convulsion. On examination nothing could be found except indications of bronchitis, and it was treated for that without any reference to the convulsions, which however continued about three times a day. In the course of my visits I detected transitory squints. In sixteen days bronchitis had disappeared, and likewise the convulsions. From its birth the bowels have been obstinately constipated, and phosphate of sodium was recommended to be used in the milk, but without any effect. On January 5, 1887, it commenced to have convulsions frequently, without any bronchial symptoms; temperature 102° . It was treated with chloral and calomel purges, the only effect being to cause a cessation of the symptoms for an hour after the chloral was administered. In about two days the head was noticed to have increased in size, the bones were further apart, and pulsation could be seen between the bones. At this period iodoform-inunction was commenced, but the size of head still increased until it had reached about twice the normal bulk. On the 10th I watched the child for an hour, and during that time it appeared dead, the face being very pale, and the movement of the chest scarcely visible; in about ten minutes it opened its eyes, raised its head, had a convulsion, and resumed its former position; this occurred four times within the hour. The treatment was perseveringly continued, and the symptoms gradually improved until finally it recovered and is still alive. As it was recovering I noticed a contraction of the fingers of the left hand and rigidity of elbow and apparent loss of motion, but no atrophy or loss of sensory power; this, however, has disappeared. After the ointment had been

used for some time, pustules with a thick red areola appeared, in number about twenty, and distributed equally over the head. The family history is good, no phthisis being known, but one infant died of convulsions at ten months old, having had them several days after birth and again at six months old, without any apparent reason except in the final instance when it had measles.

CASE 5.—A female infant æt. nine months. On February 8th the child, previously healthy, commenced to suffer from bronchitis and was treated accordingly. There were loss of sleep and signs of pain in the head, constipation, elevation of temperature, and vomiting, all of which might have been attributed to the bronchitis, until on the 10th the head commenced to swell and continued to do so for two days. Iodoform-inunction was commenced, and in about three days the symptoms improved. About this time I asked a brother practitioner to see the case with me, and he concurred in my diagnosis of meningitis. In this case there were no convulsions, but there was a transitory squint and a fixed stare. The child is still alive and well.

It will be noticed that the three successful cases occurred in infants before the bones of the head had coalesced; but the treatment in all cases was not commenced until the disease was well-marked, and the improvement in all cases appeared in less than a week. In all the successful cases the mothers spoke of the appearance of a red spot on the right temple, without any suggestion on my part. The results appear to me to encourage the further trial of the treatment, and as soon as possible after the diagnosis is made.—*Practitioner*, May, 1887.

Dabney (W. C.) on Nitro-Glycerine in the Treatment of Epilepsy. —A girl, fifteen years of age, of bad family history—her mother and grandmother having died insane,—had been a sufferer from epilepsy for two years. Her general health was good and her menstrual functions properly performed.

I saw her first November 1, 1885; she was then having convulsions almost every day, and sometimes twice in twenty-four hours. The bromides had been faithfully tried with but partial relief. She was at once placed upon nitro-glycerine, one drop of a one per cent. solution being given her three times a day. She had a convulsion

on November 9, 1885, and did not have another until November 1, 1886—the nitroglycerine having been continued without intermission during the whole of this time. On November 13, 1886, I saw this young lady again; she had then had two slight convulsive seizures and had on several occasions been “dazed,” as she expressed it. The dose of nitro-glycerine was increased to one drop and a half three times a day, and she has had no return of either the convulsions or the “dazed feelings” since.

In view of the fact that the *hygienic* management was precisely the same before and during the administration of the nitroglycerine, it seems fair to attribute the benefit in this case to its use.

In another case the convulsive seizures were kept under control for some weeks; but it was impossible to induce the parents of the patient in this case to persist in the use of the remedy, they having been taught that epilepsy was incurable. In several other cases which have fallen under my observation there has been improvement, but there has not yet been a sufficient interval of time since the treatment was commenced to say what the ultimate result will be.—*N. Y. Med. Record*, April 16, 1887.

McKenna (T. M. T.) on Erysipelas as a Therapeutic Agent.—

CASE 1.—Mrs. B. H., aged forty-five years, widow, admitted to Dixmont, June 1, 1882. Had been insane for some time, exact time unknown. Case of chronic mania. Remained in a stationary condition until February, 1885, nearly three years from time of admission, when an attack of facial erysipelas occurred, and immediately she became sane. Was kept until June, 1885, when, no relapse taking place, she was discharged.

CASE 2.—Miss E. M., aged forty-two years, native of Massachusetts. Has been in Danvers, Northampton, and other asylums, at intervals, since ten years of age, when she became insane from an injury to the head; depression of skull in middle occipital region could be felt. She had had several intervals of sanity, each of two or three years' duration. Her mother suicided. Case of chronic mania; talks at random; irritable; running away from home, etc.; had the worst tongue of any woman it was ever my misfortune to meet. Admitted to Dixmont June 14, 1884. Remained in stationary condition until February 7, 1886, nearly two years, when an at-

tack of facial erysipelas occurred, and immediately she became sane. No relapse taking place by April, 1886, she was discharged on that date.

How the erysipelas acted upon these two cases cannot be known. In several other cases I noted great changes in the mental condition of patients after an attack of erysipelas. Inoculation with mild erysipelas in chronically insane persons may enter into the therapeutics of insanity. Fear of an untoward result deterred me from trying it. I can find nothing on the literature of the subject, save that acute febrile conditions sometimes exercise a beneficial influence over cases of insanity.—*Pittsburgh Med. Rev.*, March, 1887.

Goldmann (E.) on the Use of Blisters.—“I was requested one day to see a child which had had the measles some weeks previously, but the catarrhal affection of the bronchi continued in this case. In an evil hour the physician prescribed rather a good-sized blister to be placed on the middle of the chest. The consequence of it was not only no amelioration of the bronchial catarrh, but a deep inflammation of the skin, which assumed a diphtheritic character, causing sloughing of integument with copious ulceration. The edges of the destroyed surface were anæmic and ragged, the ulceration extended beneath them to some extent, so that they overlapped a part of the real wound. Tonic treatment combined with stimulating and astringent embrocations were commenced forthwith, but the marasmus, which had ensued, and the abundant ulceration, which I vainly tried to overcome, did not fail to carry the child to the grave.”

The author also narrates a case of acute gastro-enteritis and one of dysentery which ended fatally, with uræmic symptoms apparently induced by too free use of blisters.—*Tex. Cour. of Med.*, April, 1887.

Hutton (T. J.) on Tannic Acid as a Surgical Dressing.—Tannic acid forms an excellent dressing in three classes of wounds, viz.:

1. Incised wounds—applied after the sutures are inserted, or adhesive plaster is on—if the wound does not require stitching.
2. Small wounds of irregular form and recent occurrence.
3. Wounds of moderate size in compound fractures. Wherever applicable it excels all other dressings in the following respects:
 - a. Convenience.

- b. Cheapness.
- c. Cleanliness.
- d. Efficiency.

It is always ready. It costs but a trifle. It requires no greasy mixing, measuring or muddling and has neither smut nor smell. While of its efficiency I can only say after sixteen years' use that I am satisfied : I ask nothing better. I first called attention to this neat, choice dressing in an article entitled "Fifty Fractures in Mining Surgery," which appeared in the *Medical and Surgical Reporter* for September, 1878.

The method of application is simply to keep the wound covered with the powder. Wounds thus treated heal on the average in about one third of the time required for similar ones treated by liquid, oily, or salve dressings. In converting compound fractures into simple fractures by this method, the flesh wound is often healed in one twelfth of the time required to heal it by wet dressings or salves that are frequently removed and re-applied. Illustrations are unnecessary if I have clearly defined the classes of wounds in which this dressing is applicable. Although hundreds of cases thus treated could be adduced that would prove interesting reading, I will describe the last case only in which this dressing was employed :

F. J., aged 16, German, on January 26, 1887, was struck by a falling tree. Next day he was brought to my office. There was a semicircular scalp wound six inches in length over left parietal bone, and a fragment of this bone, almost the size of a silver quarter dollar, stuck up trap-door fashion. The flaps had shrunk wide apart and were swollen and angry, as the injury had occurred twenty hours previously. The whole wound looked bad, being full of hair, dirt, serous effusion, chips, leaves, and brush-wood. The patient was very feeble, but conscious. A dose of whisky and hot water was administered and the wound doused for one hour with warm carbolized water. When the bony fragment had been gently depressed almost to normal position, (I could not succeed in reducing it to the normal level) the scalp-wound was sutured with horse hair. Tannic acid was then applied, and directions given that it be dusted on freely every few hours, more especially if moisture should appear over any part of the wound. A laxative was administered, also small doses of aconite and bromide of potassium.

The flesh wound healed by first intention. No fever ensued ; the pulse never exceeded 92. The patient went home on the 31st—the fourth day of treatment, and two weeks later his father reported that he was "all right."—*Jour. Am. Med. Ass'n*, April 30, 1887.

Scott (J. Z.) on the Use of Galvanism in the Treatment of Indolent Ulcers.—Attention is again called to this long-known but neglected therapeutic procedure by the report of a case occurring in a man of 20, on whose leg an ulcer had remained unhealed fifteen years. The ulcer, which was situated an inch above the internal malleolus, extending across the leg transversely to the subcutaneous border of the tibia, and internally about two inches, was painful and very tender, but was indolent as to its general characteristics.

Local applications and constitutional treatment never gave relief until he commenced the use of the galvanic battery. The secretions of the ulcers were noticed to be alkaline, and the negative pole was placed to the ulcer, the positive to some indifferent point, and six cells were taken into the circuit ; the séance was prolonged about ten minutes. From that time the ulcer began to get well, and a half-dozen applications ended the case. He applied the bare silver plate of the negative electrode directly to the diseased surface. The other treatment was also persevered in.—*Therap. Gaz.*, April 15, 1887.

Muscroft (C. S.) on a New Method of Preventing Hemorrhage and Treating Aneurisms.—Under the above head the author describes his experience in the use of acupuncture previous to amputations as a substitute for digital compression, the tourniquet, and Esmarch bandage. He was led to an enthusiastic belief in the wide-reaching importance of this method by a successful application of it in a case of amputation at the hip-joint, and in one of amputation at the shoulder. In the former case the method of employing the compression is described as follows :

As soon as the patient was fully under the influence of the anæsthetic, a needle, one eighth of an inch wide, slightly bent at the point, about the thickness of a dime, and four inches long, was introduced perpendicularly into the front of the thigh, about an inch and a half below Poupart's ligament. The exact point of entrance was one fourth of an inch internal to the

combined sheaths of the vein, artery, and nerve. The point was pushed beyond the vessels, and then turned outward until the needle had passed beyond them; the point was then pushed out through the integument. The needle was then behind the vessels and nerve. A piece of cord was passed under the heel and point of the needle, forming a figure-of-eight ligature. Before the ligature was applied the femoral artery could be felt pulsating strongly, but when it was tightened the pulsation below the needle had ceased entirely.

After the incision had been made, the femoral artery was found to be perfectly compressed.

Dr. Muscroft also claims that this method will be found useful in the treatment of aneurism in any part of the lower or upper extremities. He has found that the steel pin can be retained, without causing irritation, for four days. Then, if necessary, it can be removed and another introduced lower down.

While admitting that acupressure was an old surgical procedure, Dr. Muscroft claims that its application in the prophylaxis of hemorrhage, and in the surgical treatment of aneurisms, is new. The points made were summarized as follows:

1. The simplicity and easy applicability of the method.
2. There is no interference with the general venous circulation in nearly all cases.
3. The plan is so simple that it does away with all of the more complicated forms of compression of vessels by tourniquets, bandages, or tubing.
4. It is also a process for shutting off the arterial flow in cases of aneurisms.
5. The introduction of the pin or needle will, in most cases, be an entirely bloodless operation, and attended with very little pain. The pin used may be straight, bent at the point, or of any curve or shape to suit the operator.
6. It is also a ready, safe method of arresting hemorrhage in recent accidents from compound fractures or other causes.
7. Many cases will fall under the observation of the practising surgeon in which its utility will suggest itself.
8. The kind of metal of which the pin or needle is made is a matter of the utmost importance, experience teaching that steel or iron produces less irritation than the more costly metals, such as gold or silver.
9. Freedom from septicæmia.

10. The great facility with which the operator could obtain a pin suitable for the compression. For one of the larger vessels it could be obtained from a lady's toilet supplies, by using any of the long steel pins with glass heads, especially those used for fastening on their hats. Their being straight in most cases would be an advantage.

11. This manner of preventing bleeding in operations about the the hip-joint (excision), shoulder-joint, or knee, will be of the greatest importance.

12. It does away with the necessity of a most important assistant.—*N. Y. Med. Record*, May 14, 1887.

Wilkinson (C. H.) on Carbuncle Successfully Treated with Carbolic and Salicylic Acid Injections.—On December 26, 1886, a man, aged thirty-three, tottered into my office, and threw himself, or rather fell, into a chair, exclaiming, in a feeble voice, that he had a carbuncle, and desired me to treat it. The diseased process extended from the "inferior occipital ridge" to the fifth cervical vertebra, and nearly from ear to ear, and had then existed for fourteen days. The integument intended in the space just mentioned was perforated by fifteen or twenty minute sinuses, through which a thin, yellowish, offensive pus, or rather ichor, was exuding at the rate of several ounces daily, while so tender and painful were the parts involved that opiates had to be taken in order to secure any repose whatever, day or night.

His general condition was very much below a healthy standard. He was pale, feverish, nervous, and haggard; all the result of the terrible affliction he was carrying around on the back of his neck, and had been sent to me by his former medical attendant in order to receive the benefit of the carbolic-acid treatment.

The disease, however, had progressed too far to receive the abortive plan of treatment, *i. e.*, injection of pure concentrated carbolic acid into the most prominent sinuses, so I directed the following wash to be used, diluting it from time to time as occasion required:

B	Carbolic acid	i.
	Salicylic acid	i.
	Borax	3 i.
	Glycerine	i.
	Alcohol	i.
	Oil of sassafras	3 i.
	Water	℥ i

Selecting an ounce syringe of the undiluted mixture, I injected the same through some two or three of the most prominent sinuses, *and out in the direction of the most indurated portions of the carbuncle*, while a weaker portion was injected into the centre of the diseased tissues in order to clean and stimulate that portion of the ulcer. No pain was complained of by the patient from the use of this application, and having cleared away all exudation of pus and shreds of necrosed cellular tissue, I applied absorbent cotton and a well-fitting roller bandage around the neck and forehead, and directed him to call again on the next day.

The preceding plan of treatment was pursued daily thereafter for about a week, when it was found that the disease was fairly under control, and that the stronger washes could be dispensed with. Weaker solutions—1 part to 6 of water—were used, however, for two or three weeks longer, merely in order to clear away débris, and to stimulate healthy granulations.

A tonic of quinine and iron was given thrice daily, the patient directed to eat well and exercise in the open air, and the washes were kept up until the 10th day of March, 1887, when Mr. B. was discharged, well and hearty, and full of thanks for the happy termination of so dreadful a malady.—*Tex. Cour.-Record of Med.*, April, 1887.

Williams (D. S.) on Oil of Black Pepper in Cinchona Dermatitis and Urticaria.—During the fall of 1866 I was in attendance upon Mrs. McC., aged twenty-three, married, for an attack of intermittent fever. Ordered the usual treatment—quinine, etc.

On calling next day I found her suffering from a violent attack of urticaria. She stated that I must have given her quinine, that it had always produced the same trouble since she was fourteen years old. Ordered cinchonid. sulph. grs. iii; xanthoxilin, gr. ss; and ol. pip. nig., gtt. ii, every three hours, six doses, with the best results, the rash disappearing in 8 or 10 hours.

Some weeks later, in a similar attack of fever, I ordered quinine sul., xanthoxilin, and ol. pip. nig. No rash occurred. Being her physician for the next fourteen years, I never gave her quinine without the oil, and whenever she would take the quinine alone the rash would appear. I attributed

the effect of the quinine to an idiosyncrasy, and that relieved by the oil. I gave no thought as to its possible prophylactic properties till the summer of 1881, although frequently combining it with quinine, when the following cases presented:

Jas. M., aged twenty-six, diagnosis remittent fever. He stated that he could not take quinine, as it always gave him nettle-rash. I, however ordered quinine sul., grs. iv; pill. hydrg., grs. ii; gelsemin, grs. 1-6; ol. pip. nig., grs. ii, every three hours, taking six doses, commencing at 10 A.M.; slight itching of upper extremities and body occurring in ten or twelve hours. Have prescribed frequently for him since, where quinine was indicated, combining the oil, with good results.

April, 1886, Mrs. W., aged twenty-two, married, eniente three months. Intermittent. States she can't take quinine on account of nettlerash. Prescribed: Quinine bisul., grs. xx; hydrg. submur., grs. vi; extr. hyos., grs. ii; gelsemin, gr. ss; ol. pip. nig., gt. xv; M.; ft. capsules, No. 6; Sig. one every three to four hours. In eight or ten hours slight tendency to rash; would not believe she had taken quinine. She takes quinine combined with the oil when the former is indicated, experiencing only slight itching at times.—*Tex. Cour.-Record of Med.*, April, 1887.

Corson (H.) on Rhus Glabrum in Stomatitis.—The first notice I ever saw of the use of sumach was in the May number of the *American Journal of the Medical Sciences* in 1829, in a paper by Dr. Wm. Fahnestock, entitled "On the Rhus Glabrum as a Remedy for Ptyalism."

In December, 1836, I was called to attend a sea captain who had been badly ptyalized in Cuba when under treatment for "liver complaint." When I saw him at the house of his friend here, he requested me not to use any form of mercury when treating him, because he had suffered so greatly on the former occasion, and so long, that he was compelled to go to England for change of climate in order to get well. I spoke to him of the curative power of the sumach, but he would not yield; so I did the best I knew for a few days without the mercury, and without any benefit to him, and then cautiously gave him some; fearing that I might have trouble with him, knowing full well that when a person has once been ptyalized by mercury, a very little will produce it again. On going into

his rooms a few days later, I at once discovered the mercurial odor, and at the same moment he began to upbraid me in choice seafaring terms for what I had done. He was at once given the sumach infusion, or decoction rather, with which he washed his mouth thoroughly and often, and was soon well and delighted with the remedy. He also took at the same time the infusion of Peruvian bark, as directed by Parrish and used by Dr. Young.

So year after year, as cases occurred, I treated them,—the mild and the severe, the baby's sore mouth, and all the grades up to the gangrenous sore mouth—with the sumach as the local application, in many of them using nothing internally beyond the mouth, except in one case.

On one occasion in a violent, rapid cancrum oris, which had so far advanced when I was called that it seemed as though the disease would soon pass through the cheek, I feared to delay, feared the sumach would itself be too slow, so swabbed out the gangrenous ulcer with nitric acid, and followed that with the sumach mucilage, with the most saving result.

It would be quite useless to call up the numerous cases which have presented themselves in a half century's daily practice, in all of which I used the sumach mucilage with comfort to the patient and satisfaction to myself, but I may mention a single case which occurred. In August, 1881, was called to see a granddaughter of John Downs, a healthy Scotchman, living at Spring Mill, who was suffering greatly with ulcers on the cheeks, roof of the mouth, and on the gums and side of the tongue, with a copious secretion and most offensive breath issuing from the mouth. The little thing was complaining heavily, and what they had put into her mouth for relief had so hurt her that she had a fear of everything offered to her. As the sumach was abundant, not fifty yards from the house, among the hornblende boulders on the hill, it was soon dug and prepared for use. It was so mild as to be, instead of painful, most comfortable, and was used without other remedies save a mild cathartic or two. I began on the 12th; in recording my last visit on the 20th I find this record: "The sumach was a success." She was not only well, but from the hour she began it she was comfortable, a matter of some moment to a child only a few years old.

What else shall I say? That I had a

dread of sulphate of copper and the bichloride of mercury. It is difficult to use them with children and have the parents to use them in our absence without danger of their swallowing the secretion, carrying with it some of the poison, especially when used as the corrosive sublimate was—eight grains to the ounce of water. With the sumach I felt safe. The root of the sumach has a thin outer mahogany-colored bark, thin as blotting-paper, which, when the root is freshly dug, is readily scraped off with the back of a table-knife, but if left until it dries can hardly be removed without cutting it off; under that is a thick, succulent, white bark, easily shaved from the wood. This, when dried, keeps well; this put into a clean white bowl and covered with boiling water, and even boiled, soon becomes a mucilage without taste or smell, and is ready for use. I generally procure it in the fall, and have it carefully dried.—*Med. and Surg. Reporter*, March 12, 1887.

Porter (W. H.) on the Effect of Antipyretic Drugs on the Liver and Kidneys.—At a recent meeting of the N. Y. Path. Soc., Dr. Porter presented the liver and kidneys of a patient who had had a moderate attack of rheumatism. Later, antipyrine was given at rather short intervals for the purpose of reducing the temperature, but it seemed to have had little influence. When the patient entered the hospital the temperature was 105° F., and after antipyrine was given it rose to 107°. Antipyrine was omitted and salicylic acid was given, when the temperature fell to 103°. Antipyrine again being given, the temperature again rose. Antifebrine was also given, but the temperature rose higher and higher, and the patient died with a temperature of 109° or 110° F. In looking over the literature he had found that some men who had experimented with such antipyretic drugs as antipyrine, antifebrine, thalline, etc., had observed the appearance of casts and albumen in the urine, and at the autopsy extensive metamorphosis of the liver and kidneys; but they claimed that this was of no practical importance. Some had also observed that in patients treated with antipyretic drugs, especially typhoid-fever patients, the duration of the disease was longer,—forty-two days instead of about thirty-two days, as was observed when baths and antipyretic measures other than these drugs were resorted to. One

writer had said that by the use of antipyrine he had succeeded in getting the highest death-rate, but he was inclined to think that the patients were more comfortable while they lived. In studying the condition of the kidneys and liver in cases in which these antipyretic drugs had been employed, Dr. Porter had noticed in the history that the temperature had been higher than in cases in which such drugs were not employed, and he found a much greater degree of granular and fatty metamorphosis in the liver and kidneys. He had therefore come to believe that antifebrine, antipyrine, and thalline were not as safe drugs as we had been taught. The effect of the increased temperature occurring at some period of the disease after their use was to cause this marked metamorphosis of the liver and kidneys—primarily of the liver, secondarily of the kidneys.—*Phil. Med. Times*, April 16, 1887.

Huber (L.) on the Rational Uses of Alcohol in Pulmonary Phthisis.—The rational uses of alcohol in pulmonary phthisis must be guided by the following conditions :

1. Begin early in the disease, when the first evidences of consolidation and subsequent softening of the lung tissue can be ascertained.

2. Ascertain the capacity of the system to consume alcohol. This will need close scrutiny into the action of the liver and lungs. If there be a degree of tolerance greater than that of health, administer the agent to the extent of it, but do not carry it beyond. If no tolerance exists, and the functions of the system are disturbed by a careful administration of the remedy, examine into the external conditions of the patient—the food to which he has been, and perhaps yet is, habituated ; the climate ; the likely action of the drinking water on the powers of alimentation and the liver ; the atmosphere and altitude. By changing these, which may often be radically done by a removal of the patient to another country, to a mountainous, elevated region, where an out-door life is endurable, this want of tolerance may be overcome. Indeed, it is known that persons have been thus saved from further progressive inroads of the disease. In certain mountain altitudes there is, as already remarked, such a degree of tolerance, that intoxication from alcohol could follow only the grossest abuse of the agent. The writer has the

record of several cases removed from the low Atlantic seaboard to the table-lands of the Rocky Mountains, in which the capacity to use alcohol as a nutrient increased from less than three ounces of good whisky daily, to the average quantity of twenty-six ounces in the twenty-four hours, accompanied by the most marked improvement of the patients in every respect.

3. When the appetite improves, the digestion is healthy, the cough and expectoration lessen, the frequently attending dyspnoea disappears, and the respiration is slower and deeper, under the use of alcohol, no better agent can be found for that particular case. In alcohol the patient will find a new lease of life, if not salvation from the disease. If, moreover, a cavity has formed in the lung tissue, and the sputa therefrom lose their fetid character upon the ingestion of alcohol, there is the further evidence that the agent is keeping in check systemic infection, and thus preserving the system from the first rapid inroads of the disease.

With a few facts thus formulated, a physician should surely manage his cases of pulmonary phthisis far more satisfactorily than by pursuing the usual routine method. Besides, it will be a serious matter with him to use discriminately this useful agent. There are some serious considerations to be recalled. It is not a trifling matter to insist upon the use of an enslaving agent like alcohol. The course must be justified by well-defined aims. How often under the indiscriminate use of the agent has a life of drunkenness been engrafted ! This has never followed, the writer will venture to say, the scientific, therapeutic administration of alcohol. The late Dr. Flint asserts that it is extremely rare for a taste for alcohol to be engrafted when its use is properly defined, and his experience has been extensive.—*Med. and Surg. Reporter*, April 2, 1887.

Wagner (W. G.), (Indiana), on Direct Oxygenation in Croup as a Substitute for Tracheotomy.—Having a case in which the parents refused to have tracheotomy performed, I was forced to cast about for other means of relief. Intubation not having been advocated at that time, I resolved to furnish the required amount of respirable air by generating oxygen. Conducting the current of oxygen beneath a cone placed over the child's face, I was soon gratified by seeing him fall asleep.

This and two other successful cases, with one reported to me by my friend, Dr. J. B. Greene, is the extent of my observation ; but from the fact that the object of tracheotomy and intubation is to furnish oxygen to the blood, the direct application of pure oxygen seems to me to be worthy a more extended trial. The relief afforded seems to be about the same ; perhaps a little more rapid than in tracheotomy. I think the method has these advantages ; the membrane cannot extend below the incision, and thus render the operation useless ; it does not cause broncho-pneumonia, as intubation sometimes does ; and all physicians are not prepared to tracheotomize or intubate, while any one can generate oxygen and apply it. Also oxygen seems to lend more strength to cast off the membrane, and the trachea is not encumbered by a tube or a false outlet for expulsoy air from the lungs.—*Br. Med. Jour.*, April 16, 1887.

Treves (F.) on a Form of Glandular Swelling Curable by Arsenic.—

The author drew attention to the obscurity that attended both the pathology and the clinical history of certain chronic glandular affections. These affections were covered by such terms as the following : hypertrophy of glands, malignant lymphoma, lymphadenoma, Hodgkin's disease, and lympho-sarcoma. These glandular swellings were considered to be un-inflammatory, had no relation to scrofula or syphilis, and were clearly separated from the gland disorders that attended leukæmia. They possessed the common characters of a slow origin without apparent cause, a slow but progressive growth, and an absence of all inflammatory phenomena. Histologically, there would appear to be no means of distinguishing one of these affections from another. Apart from this, objections might well be raised to the terms "hypertrophy," and "lymphoma." Without limiting himself to any special term, Mr. Treves desired to call attention to the clinical aspects of a certain form of non-leukæmic gland enlargement that could be cured by arsenic. The patients were usually past middle age ; they presented no peculiar constitutional defect ; there was no suggestion of gout, rheumatism, or scrofula ; there was no leukæmia. The neck was usually involved. The gland tumors appeared on both sides without disturbances in the periphery. The masses varied in size from a hazel-nut to a duck's egg. They were soft, elastic, homo-

geneous, movable, painless, and free from tenderness. They showed a disposition to spread without limit. The temperature was normal, and suppuration did not take place. Mr. Treves gave instances of the cure of such cases by the use of arsenic. The drug was given in the form of liq. arsenicalis, commencing with a dose of five minims, and increasing to twenty minims three times a day. The treatment had to be kept up for some months—one to six ; the glands wasted, some few suppurated, and in some instances the resulting sinuses healed without further treatment. In cases where the whole neck had been filled with great glandular masses, the tumors had wholly disappeared after a treatment of four to six months. Some of these cases, at least, would probably be covered by the term "Hodgkin's disease."—*Br. Med. Jour.*, April 2, 1887.

Norderling (K. A.) How Should Santonin Be Prescribed to Obtain Its Full Physiological Effect?—

After the introduction of santonin into the system, the urine will in a short time become of a cherry-red color. Santonin will give the same color when dissolved in an alkaline solution, or when heated to liquefaction with the addition of caustic potash. The drug, therefore, undergoes in the system a change similar to that produced by alkalis and heat. Santonin is insoluble in water and dilute acids, but dissolves in the saliva, the gastric, intestinal, and pancreatic juices. This solution in the gastric juice takes place so rapidly that the maximum dose is completely absorbed in the stomach, as has been shown experimentally by Lewin. But it has also been proved by experiment that santonin, when given in an oily solution, is not at all absorbed in the stomach, but the entire quantity passes into the intestine. It is evident that when the drug is given in powder it will be absorbed and taken up in the circulation before reaching the intestine, and consequently, in order to obtain its vermifugal effect, it must be administered in such a form that it will not be acted upon by the gastric juice. Küchenmeister has shown that the drug must be in solution, as he found that ascarides were not affected by santonin crystals floating in water, but were killed when brought in contact with an oily solution of the drug. In order, therefore, to accomplish its therapeutic object, it is necessary that santonin be in a form in

which its vermicial action can be exerted, and also that it reach the habitat of the parasite. To make the solution, any form of oil may be used, and the best effect is obtained by three grains of santonin dissolved in two ounces of oil, to be taken in four doses. It is also a good practice to add one drop of wormseed-oil to each dose, as researches have shown that all ethereal oils are poisonous to the lower organisms. If a movement of the bowels is desired, castor-oil will be suitable, although not in too large a dose, because with strong peristalsis the santonin does not remain long enough in the intestine to produce the desired effect. About two drachms of the oil to each dose will be sufficient.—*N. Y. Med. Record*, April 23, 1887.

Buckingham on *Tænia Saginata* Removed by Pelletierine.—This worm, otherwise called *tænia mediocanellata*, is the worm of the cystircus of beef, and is said to be the most difficult of the human tape-worms to expel. With this particular worm success followed only the seventh attempt, which was made with pelletierine, the previous attempts being with male fern and with pomegranate. One of the attempts with male fern, which was made by another physician, was nearly successful, bringing all but the head.

In looking up such authorities as had come in his way, the speaker had become impressed with the fact that while there is strong evidence that kameela and kouso are very effective in their own countries, yet turpentine and pomegranate seem to be universally well spoken of. The statement is made by Tanret that pomegranate varies in its power according to the age of tree as well as the climate, and also with the time of year when it is gathered; also that it deteriorates with age. Pelletierine is one of the four active principles of pomegranate.

It is said to be the fact that the sulphate if given alone, is too rapidly absorbed with possibly dangerous effects, but that the tannate, which has, however, a bad taste, or the sulphate combined with tannic acid are safer; the dose of the sulphate being three decigrams, with the addition of tannic acid. His patient had taken it in the form put up by Tanret, but there seems to be no reason why an extemporaneous prescription should not be written. Soon after taking the medicine there was some flushing of the face and peculiar sensation in

the head, with so much nausea that a cathartic, directed to be taken in half an hour, could not be taken for an hour and a quarter. It is worth while to call attention to v. Schroeder's experiments with this drug, in the laboratory of Strassburg, which agree with the clinical results of many observers, that the pomegranate should be taken in one or two doses; and not as recommended in the United States Dispensatory, in small doses repeated over a considerable time. This last has the further disadvantage of unnecessarily prolonging starvation.—*Bost. Med. and Surg. Jour.*, April 21, 1887.

Busey (S. C.) on Persistent Vomiting during Labor Relieved by Anæsthesia.—In a young woman who during a former pregnancy had suffered constantly from nausea and vomiting, Dr. Busey found a sharply pointed exostosis jutting obliquely upwards from the inner surface of the ramus of the pubis immediately below an external and larger tumor, measuring (approximately) three fourths of an inch in length. The upper border of its base seemed to be on the *linea ilio pectinea*; otherwise the pelvis seemed to be normal.

In due time labor came on and the rest is narrated in the doctor's own words: "With the end of my index finger against the most dependent portion of the bag of waters during a pain, I frequently recognized the simultaneousness of the beginning of the vomiting and subsidence of the uterine contractions, and their correspondence with the moment when the pain or contraction had reached its maximum intensity. If this observation were correct, and the method adopted correctly measured the duration and degree of the uterine contractions, no progress in the labor could be expected during the continuance of the conditions which produced the inertia. Three methods of relief were considered: rupture of the amniotic sac, a rectal injection of chloral hydrate, and anæsthesia. I determined to try the last first and, in the event of failure, each of the others in retrograde succession. At 11:50 P. M. I began the administration of the A. C. E. mixture. The vomiting ceased; the pulse improved in force and volume, and slowed, and the pains became more direct and distinctly intermitting. After continuing the anæsthesia for three quarters of an hour it was suspended. The vomiting recurred. The anæsthetic was resumed and not again

withdrawn until the head had escaped. The vomiting did not return.

At 1:30 A.M. I ruptured the amniotic sac, and delivery was completed at 3:30 A.M., February 9th. The sac was ruptured because its persistence retarded the labor. After the cessation of the stomachal complication nothing worthy of special notice occurred. During the progress of the descent of the head I examined the relation of the head to the exostosis several times. It did not present any obstacle to delivery. There was not upon any part of the child any mark of its impingement. The child, a female, weighed $7\frac{1}{2}$ pounds. The mother's convalescence was satisfactory, except unusual thirst and hunger during the first day, and delay of milk until the sixth.

This case is another striking illustration of the value of anæsthesia in labor. The contractions of the uterus were concentrated and increased in power. Usually I do not commence the administration of the anæsthetic before the beginning of the second stage, but I have quite frequently witnessed a similar result when, in consequence of some perturbation, the uterine contractions seem to be ill defined, diffused, and as it were wasted. In very many cases anæsthesia expedites labor, in a few it retards it, and in very rare instances it is not well borne, and has to be withdrawn. During the past two years I have most frequently employed the A. C. E. mixture with satisfactory results. It seems to be equally effective in lessening suffering, with less narcosis.—*Jour. Am. Med. Ass'n*, April 30, 1887.

MEDICINE.

Brown-Sequard on the Different Effects of Irritation of the Anterior Cervical Region Particularly as Regards the Production of Anæsthesia and Death.—The author had often wondered that suicides were able to cut their throats to the bone and even inflict upon themselves many other deep wounds which implied an almost superhuman courage because of the excessive pain they seemed to inflict.

He, however, discovered that a trifling wound in the skin of the neck in the neighborhood of the larynx abolished sensibility in the anterior two thirds of the neck, and often in other regions as well. Making a longitudinal incision to expose the larynx

and trachea, he found produced pretty widespread anæsthesia, which persisted until cicatrization was nearly complete, and in the immediate neighborhood of the wound for some time afterwards. In dogs and monkeys he has found this cut produce an almost complete analgesia throughout the limbs, trunk, head, buccal, and ocular mucous membranes. The author has long since demonstrated the possibility of producing analgesia and anæsthesia by irritating the laryngeal mucous membrane, and he concludes that the skin of the neck also possesses this power to a less degree. His experiments also prove that death can occur by in this way exerting an inhibitory action on the heart. In this way he explains those deaths by suspension where neither the neck is broken nor the air passage occluded.—*La Thérap. Contemp.*, April 29, 1887.

Eliot (L.) on the Prophylaxis of Diphtheria.—When called to a case of diphtheria, or one which has a suspicious appearance, in addition to ordering calomel, iron, chlorate of potash, and insufflations of washed sulphur, I direct a dish of oil of turpentine to be placed upon the stove over a water-bath and the vapor allowed to saturate the air of the sick-room; of course, if any of the disagreeable effects of the vapor should follow, use it more sparingly: there is but little danger of its catching fire, if attention is paid to it. This has been my practice for some time, and in every case where I have employed it no other case has developed.

On January 31, 1886, I circumcised a child two years of age. On the fifth day following, diphtheritic inflammation attacked the penis: the throat soon became involved. The usual remedies which I have mentioned were ordered in addition to the vapor of turpentine; this vaporization was carried out so faithfully that the air of the entire house was saturated. This case recovered and was the only one developed in the house. Early in 1886 I was called to the most horrible cases of diphtheria I have ever seen. The physician in attendance had treated them most faithfully, even spraying the throat and nares with a solution of bromo-chloralum every half hour. Substituting insufflations of sulphur for the bromo-chloralum and ordering the vapor of turpentine, I left to return at 10 45 the same evening. At the second visit, as the cases were no worse, it was decided to post-

pone surgical interference. Morning showed much improvement. The surroundings of these children were encouraging in the extreme. Living in four rooms the two families had free access to their sick, while, in addition, one mother had with her a nursing baby of two months. Both of these cases recovered after a long convalescence, but no other case developed.—*Med. Register*, April 30, 1887.

Forchheimer (F. on Torticollis Intermittens).—The author concludes that the poison of malaria sometimes localizes itself at the roots of the nerves supplying the superficial muscles of the neck (especially the spinal accessory).

This poison may extend from the nerves to the mehinges of the cord or brain, or to both.

A relation exists between the poison of malaria and sporadic cases of cerebro-spinal meningitis.

The ordinary treatment for malaria usually suffices for this peculiar form of localization.—*Arch. of Pediatrics*, Feb., 1887.

Verneuil on the Treatment of Rebellious Nose Bleed.—His treatment consists in very active counterirritation (revulsion) over the hepatic region.

The patients upon whom he employed this method were adult males, two forty-five years of age and one fifty-nine, with a history of previous good health, and they were all taken without warning with an epistaxis of an irregular intermittent type. They had no preceding malarial history. The bleeding was not severe in any case. Ordinary hæmostatic remedies failed. The liver on examination was found in two cases diminished in size, in one case enlarged, the enlargement being probably due to some antecedent renal or cardiac disease. M. Verneuil applied a large blister over the liver in the three cases, with the result of checking the hemorrhage at once. According to the author this same method was employed by Galen.—*Gaz. Hebdomadaire*, etc., April 29, 1887.

Rood (L. D.) on a Case of Severe Epistaxis.—To prevent any further hemorrhage, if possible, as the patient was becoming extremely weak from loss of blood, the doctor applied solid nitrate of silver to the pharynx and nasal cavity, completely covering the mucous membrane. Twelve applications were made, and the patient never had another hemorrhage after the first application. One remarkable feature

of the case is that the patient can now smell perfectly, whereas before he was absolutely without the sense of smell.—*N. Y. Med. Record*, May 7, 1887.

Lefour (L.) on Retention of Urine in a Fœtus with Permeability of the Urethra.—The body of a fœtus at full term presenting by the vertex became impacted and could not be expelled.

At last the physician opened the chest of the dead fœtus and punctured the bladder through the diaphragm, withdrawing 1,600 c.c. (50 ounces) of urine. An examination of the body when delivered showed the child's urethra to be perfectly permeable but the bladder enormously distended.—*La Tribune Méd.*, April 10, 1887.

Smith (T. C.) on the Resuscitation of Asphyxiated Infants.—It is very simple. Take the infant by its lower extremities with the left hand, suspend it head downward, then with the right hand embrace the neck posteriorly, using for this purpose the thumb, ring, and little fingers, while the index and middle fingers support the head. Now hold the head and shoulders downward and comparatively still, while with the left hand the body and feet are made to sweep forward and backward from ten to fifteen times or more in a minute, until respiration is established. Each time that the body is bent forward on the face the air is pressed out of the lungs, and when bent well back again the air enters the lungs freely. Keeping the head downward causes a full supply of blood to be given to the brain. * This process does not prevent fanning, or sprinkling suddenly a little cold water on its sides by an assistant if needed for the shock it produces. Cloths wrung out of hot water can also be applied if needed. It is not good practice to lay an asphyxiated infant on its back, for if there is mucus in the mouth or throat this will tend to strangle it. If placed on its side or with the face downward this cannot occur, or, at least, is less liable to do so. If there is enough mucus in the child's throat to cause considerable noise by its rapid succussions in process of respiration, all this will cease in a little time by placing the child face downward, or on its side with the face inclined downward. In this way the mucus will gravitate away from, rather than into, the throat. Of course it can be otherwise removed, but this is an easier and a very ready way to obtain relief from this harass-

ing symptom.—*Med. and Surg. Reporter*, April 23, 1887.

Anderson (T. M'C.) on the Occurrence and Gravity of Diabetes Mellitus in Early Life.—The first case was two years and three weeks old. Five and six weeks before she began to droop; her appetite also failed somewhat, and she suffered from thirst, with progressive loss of flesh and strength. Her urine was pale (its quantity I could not ascertain), its specific gravity was 1038, and it was loaded with sugar. She died two days after her father's visit to me, and before I had the opportunity of seeing her—*i. e.*, within six weeks of the onset of her illness.

The second case was a little girl 2½ years old, who, had previously enjoyed good health. Nine days before she fell, alighting upon her hands, and was not supposed to have hurt herself at all. The following day, and more or less thereafter, she suffered from the most intense consuming thirst, with profuse urination, and a tendency to coldness, lividity, and collapse. The day before my visit, she was reported to have vomited every thing.

When I saw the child, I found that the vomiting had ceased, but that the other symptoms continued. The pulse was of fairish strength, but was distinctly irregular as to force and time; there was some emaciation, and the temperature registered 95° F. The quantity of the urine could not be ascertained, but it was very pale, intensely acid, specific gravity 1037, contained a slight trace of albumen, and a large quantity of sugar, the quantitative analysis with Fehling yielding 5 per cent. There were no head symptoms whatever. The treatment recommended was the administration of warm fluid food—saccharine, and amylaceous matters being avoided—nutritive enemata, external warmth, and a teaspoonful of brandy every hour. Granules of morphia ($\frac{1}{100}$ of a grain) were to be continued and cautiously pushed.

The day following my visit, Dr. M'Millan wrote me that although the temperature the previous evening rose to 99.8°, no improvement in the symptoms occurred, and that the child gradually sank and died at 3.30 P.M., 9 days from the first commencement of the symptoms.

A *post-mortem* examination was made by Drs. Coats and Steven, the brain being carefully examined, but nothing was found, with the exception of slight anæmia of the

brain, and some fatty change in the renal epithelium, such as might be accounted for by the intense diuresis.—*Glas. Med. Jour.*, May, 1887.

The Digestion of Milk.—M. Reichmann, of Warsaw, has recently made several experiments on the digestion of milk in the human stomach. The subject was a young man, aged 22, in robust health. The experiments were made by means of the stomach-pump, with unboiled, as well as alkaline and boiled, milk. The results were as follows: 300 cubic centimètres of unboiled milk are evacuated by a healthy stomach four hours from the time it has been taken, although the regular digestion is completed three hours afterwards. Coagulation of the milk takes place about five minutes after ingestion, and does not depend on increase in the quantity of acid, but on another agency, possibly the fermentation of rennet. During the digestion of 300 cubic centimètres of milk, the contents of the stomach show the greatest average degree of acidity (32 centimètres per cent.), at the end of an hour and a half. This acidity is owing, when digestion begins, to the presence of lactic and hydrochloric acid; the latter only appears three quarters of an hour after the ingestion of milk. Half an hour after taking the milk, the quantity of peptones is increased, and remains so for an hour and a half, after which time it becomes perceptibly less. Boiled milk (heated at from 16° to 26° C.) was taken into the stomach; 300 cubic centimètres were digested in two hours and a half; the acid contents of the stomach disappeared in three hours. After the ingestion of boiled milk, peptonization, which in that case is more energetic, begins sooner, and the clots and caseine are not so thick as when unboiled milk is given. Experiments with alkalized milk have shown that alkalization of milk prevents the peptonizing action of gastric juice. One hundred cubic centimètres of milk, alkalized by means of bicarbonate of soda, leave the stomach entirely at the end of two hours. Alkalization does not prevent milk in the stomach from coagulating under the influence of rennet. In conclusion, M. Reichmann says that the result of all his experiments on one person entirely coincided with nine previous experiments he had made.—*Br. Med. Jour.*, Feb. 12, 1887.

Parker (R. W.) on the Alleged Dangers of Starch-Containing Foods

during the Period of Infancy.—I have come to the conclusion that the dangers of starch-foods are very greatly exaggerated. I may even go further, and say that I have never myself met with cases in which I could distinctly and directly trace disorder to starch-foods.

It cannot be gainsaid that very many artificially fed children are puny and weakly, and it has come to be generally accepted that the children are puny and weakly because they are so fed. On the other hand, an analysis of any 100 wasted and weakly children will show that a considerable number of them are breast-fed; and further, that of those which are being artificially fed, many were puny and weakly when artificial food was commenced, and that artificial food was either added to the nursing, or substituted for it, because the children were not thriving.

What inferences, then, are to be drawn from these facts? First and chiefly, that many children are congenitally deficient in the vitality and digestive power which are absolutely essential to their healthy development. Such children will be weak and puny on any diet. Such children as these, moreover, are just the kind of children we should expect to be born of women themselves weakly, either congenitally or from acquired causes, such as irregular modes of living, drink, poverty—leading as it does to privation of every kind: food, fresh air, light, rest, etc.

Of 100 artificially fed children, in 8 cases the mother was not available for nursing purposes. In 17 cases she was said to be too weak to nurse. In 20 cases the milk supply was deficient in quantity. In 30 cases the milk was deficient in quality; there was a plentiful supply, but it did not satisfy the child. In 25 cases the mother was poor, and had to earn a living for her family.

I question the truth of the belief that starch foods are actively injurious, and for the following among other reasons: That many and many a child is now alive and well to testify against such a doctrine; that in years gone by, before malted foods came into vogue, hundreds of children thrived upon milk thickened with a little of one or other of the common starch-containing cereals; that there are no experimental investigations to warrant such an assertion; that, as is well known, animals, when fed on starch, do not get rickets and the dis-

eases usually attributed to starch-feeding—they die of inanition; that the starch taken in with the food passes out with the fæces unaltered. If it could be shown that the starch was broken up into other and deleterious compounds, there would be something to go upon, but, as a matter of fact, the starch passes out of the body unchanged.

One of the most deplorable matters in this connection is the growing use of artificial foods. If prepared so that the starch is all or nearly all reduced, there is an idea abroad that they may be safely ordered and given; this idea is not alone confined to members of our own profession, but prevails largely among the public. As a result, much less cogent reasons now suffice than formerly to warrant the substitution of artificial food, either in part or entirely, for the breast-milk. Unfortunately, the privation of mother's milk is seldom the only privation which results from the practice of artificial feeding. Among the poorer classes—and it is essentially among these classes that the worst effects of artificial feeding are seen—deprivation of the mother's milk means deprivation of a mother's care, of the thousand and one little attentions which are as essential as suckling to a delicate infant. Quite irrespective of the diet itself, artificial food needs immense care in its modes of preparation, and I find that the troubles which are attributed to this kind of food, as often as not depend on its faulty preparation and administration. Not in this particular only are the mothers wanting in experience and knowledge. In poor homes, where life is a perpetual scramble, a veritable struggle for existence, there can be very little of that home-teaching which is such an important element in successful housekeeping in better stations of life; the girls grow up, marry, and become mothers without having been taught any of the duties which pertain to motherhood. Among the better classes there is less mortality among the infants, for all the conditions of life are better. Nevertheless, there are many weakly, athreptic, and artificially fed children even among the richer classes, for the congenital debilities of which I have spoken obtain also among these classes; after birth, however, the children, being much better cared for, gradually overcome this debility, and finally grow up notwithstanding.—*Brit. Med. Jour.*, April 9, 1887.

Artificial and Hyper-Alimentation in Phthisis.—In an account of the effects of artificial and hyper-alimentation, as practised in Professor Pel's wards in Amsterdam, Dr. van Eeden states that the meat-powder treatment introduced by Débove (which he had had an opportunity of studying in Paris) is always of service in phthisis when the disease is not very far advanced, and when it is not of a "malignant" nature. The cases which do best under this treatment are those in which there is no hereditary taint and where the disease has progressed regularly, with a not very rapid loss of strength, and with only slight hectic, anorexia, anæmia, and emaciation. The chances of successful treatment are slight where the disease has made rapid progress, with a continuous high temperature. The existence of a considerable degree of pyrexia is, however, no contra-indication to the use of the treatment. If diarrhœa and gastric irritation are produced by the artificial alimentation, it is best to discontinue it. In order to accustom the stomach to the meat powder, small quantities only be given at first—not more than about half a pound during the twenty-four hours; this amount may gradually be increased to one pound and a half. The use of the œsophageal sound for the introduction of the food is considered by Dr. van Eeden as advisable in all cases, and imperatively in hyper-alimentation. Quantities exceeding three pounds of meat powder per diem, however, are not by any means always required, and should only be given when smaller amounts do not succeed, and where the patient bears the treatment well. The method must be diligently and patiently practised, and the weight of the patient accurately noted. Dr. van Eeden remarks that so little is known of the way in which hyper-alimentation controls the development of tubercle, that whoever attempts to practise Débove's treatment must be prepared to meet with many difficulties and disappointments. Notwithstanding this, however, he has witnessed some surprisingly good results from its employment.—*Lancet*, April 30, 1887.

Mollière (H.) on a Case of Compression of the Abdominal Sympathetic Which Produced Attacks of Angina Pectoris.—The patient was a sailor of 59. For ten years he had been subject to a winter cough. Two months before admission to the hospital he began

to have sharp pains shooting throughout the abdomen. A diarrrhœa set in, with tenesmus and fatty, glairy stools. Rectal examination disclosed nothing abnormal. The cough increased, and at night he had attacks of suffocation with constriction of the throat and violent palpitation. These attacks lasted three quarters of an hour and were agonizing. They caused a profuse perspiration, a sensation of coldness in the chest, and a shooting pain down the left arm. The pulmonary resonance was exaggerated, particularly at the base. There were moist râles under the clavicles. Behind, there was almost complete abolition of the vesicular murmur, with some sibilant and dry crepitant râles at the base. There was slight purulent expectoration. There was no precordial dulness or apex beat, but a strong epigastric pulsation. The heart sounds were muffled. The abdomen was painful and sensitive, particularly in the hypochondriac regions. Examination revealed no tumor or ascites.

The liver was enlarged.

On autopsy the lungs were found emphysematous and the seat of a few cancerous nodules.

The heart was flaccid, slightly dilated, and with thin, fatty walls. The coronary arteries and aorta were healthy. The peribronchial and mediastinal ganglia were healthy. The liver was three times its normal size, and studded with cancerous nodules, some of which were the size of an orange. Stomach, intestines, pancreas, and kidneys were normal.

The mesenteric and pre-vertebral ganglia were cancerous. A mass of enlarged glands behind the stomach and above the pancreas compressed and destroyed the sympathetic nerve at this point entangling in the mass the greater part of the solar plexus.—*Lyon Méd.*, April 10, 1887.

Bartholow (R.) on Fatty Heart, Weak Heart, Pseudo Angina Pectoris, and Allied States Successfully Treated by a New Method.—The author mentions foremost among the remedies a regulated diet. The sweets, starches, and fats, for the most part, are cut off from the diet, and milk, eggs, fresh meat, game, or poultry, and the succulent vegetables are given.

The most important medicine is nitroglycerine.

It lowers the vascular tension by dilating the arterioles;

It increases the rate of the heart's movements ;

It lessens that irritability of the nervous system which finds expression in spasm, especially of the nervous system of organic life.

I must not fail to mention the other remedy—arsenic. I usually prescribe Fowler's solution (two to three drops three times a day) ; sometimes Pearson's solution of the arseniate of soda (three to six drops three times a day). This remedy plays an important part in several ways :

It removes the morbid state of the gastrointestinal mucous membrane ;

It stimulates the appetite, the primary assimilation, and thus powerfully contributes to improve the nutrition of the body ;

It lessens the irritability, and the abnormal readiness of reflex action of the nervous apparatus, and imparts that influence to the cardiac and respiratory functions, which we call *tonic*. I have said nothing about iron and tonics, and all the armamentarium of supporting treatment. I have advised nothing of these remedies because they are hurtful rather than beneficial. They keep the stomach in a turmoil, interfere with the proper alimentation, and in this way retard if they do not prevent improvement. We must not lose our hold on that elementary fact—that blood is made from food and not from medicine, and that other basic truth, that the construction and repair of the tissues can only be effected by good blood.—*Med. News*, April 23, 1887.

Duckworth (D.) on the Inadequate Treatment of Anæmia.—Repose in bed for some days or weeks proves of great value ; and, if there be any pain after solid food, it will be well to suspect the possibility of gastric ulcer, and to employ suitable diet for some time. The great point I seek now to enforce is the value of iron in much larger doses than are commonly given, and the maintenance of the treatment for a prolonged period. Trousseau called attention to this matter many years ago, but his precepts have been forgotten. He considered the only limit to the amount of iron to be given was the tolerance of the stomach ; and, where it disagreed, he gave it in opium or belladonna, or suspended it for a time in favor of chinchona. He regarded the disorder—not, as is too often the case, as a simple and fleeting one, but as essentially chronic. I must add that

the fault is often on the patient's side. Having secured some temporary benefit, our cases pass away from us ; but our duty is to follow them up till we are certain that the blood is restored to, and maintained at, due corpuscular richness. I am sure, from observation of many cases, that persistent treatment with iron, in a suitable form, and in much larger doses than are commonly given, will prove the most valuable and trustworthy remedy we have in dealing with anæmia. The mental condition of many of the subjects of this disorder must not be neglected. Chagrin and unhappiness, and want of active pursuits, often retard recovery. The venous murmur in the neck is found to be the last to disappear ; but, until it is no longer heard, a case of anæmia demands treatment.

I might add that arsenic is of unquestionable value, sometimes, in addition to treatment by iron, though I am not able to distinguish the cases in which it is specially useful. It is intelligible that it should be beneficial in cases complicated with malarial impregnation, as in persons long resident in the tropics ; and its great value in cases of pernicious anæmia, where iron is useless, must not be forgotten in connection with its occasional suitability in simple anæmia.—*Br. Med. Jour.*, March 12, 1887.

Whelan (J. H.) on the Treatment of Colds.—Belladonna, quinine, and arsenic I have found useful when given separately—not so much in large as in small doses. When combined I believe them to be nearly specific—prophylactically and therapeutically, if I may so speak.

The formula I invariably use is as follows :—

℞ Quininae sulphatis, gr. xviii,
Liquoris arsenicalis, ℥xij,
Liquoris atropinae, ℥j,
Extracti gentiana, gr. xx,
Pulveris gummi acaciae, q. s. ut fiant pilulae xii.

Sig.—One every three, four, or six hours according to circumstances.

If these pills be commenced in the early stage of a common cold, *i. e.*, when the affection is as yet confined to the nose and pharynx, the affection will be nipped in the bud. At starting one pill should be taken every three or four hours, and later on every six. If a catarrhal subject has a box of these pills always at hand, he has, I believe, a weapon wherewith to meet and defeat his enemy. The longest time I

have seen a cold last whilst the patient was fairly taking these pills was three days. How the remedy acts I do not know, except it be as a powerful *Nervine* and general tonic, bracing the patient's tissues up to resist the attacks of the exciting cause of the affection.—*Practitioner*, March, 1887.

Asta-Buruaga on Forty-Five Cases of Typhoid Fever Seen at the Roosevelt Hospital.—The treatment was mainly expectant. Equal parts of milk and lime-water constituted the sole diet as long as the fever lasted. Forty grains each of subnitrate of bismuth and pepsin, divided into four doses, were given in the milk daily. Stimulants in the shape of whiskey were ordered according to requirements. Several patients drank over a quart of whiskey a day, and I really think that the giving of such large quantities of alcohol was the only means of keeping them alive.

The convalescents were allowed solid food, commencing with tenderloin steak on the tenth to the twelfth day after the subsidence of the fever, and were generally allowed to sit up about five days later.

Small doses of *Fowler's solution* of arsenic were given, with good results, when the fever was protracted.

Antipyretics were required in several cases. Antipyrine, antifebrine, the cold pack, the cold bath, and the abdominal water-coil were used.

While in the capacity of junior assistant physician, I had occasion to observe, during the summer and autumn of 1885, various undesirable phenomena following the administration of antipyrine. After a dose of the drug, the temperature fell, but the patient felt no better for it. The tongue remained dry, the pulse was weakened, annoying vomiting would set in, occasionally the patient would be seized with a severe rigor, again profuse sweating would follow, and a condition approaching collapse was often reached, not to mention the antipyrine eruption, which was a source of grave apprehension to the patient's friends. Still further, I have noticed that the temperature soon becomes accustomed, so to speak, to antipyrine; and, although the first dose is followed by a marked decrease in the fever, subsequent doses are not attended with an equal success. Then, again, in some cases, the drug is given just when the fever is undergoing its natural diurnal remission, and then all it accomplishes is to accelerate this process

and render the remission greater. The course of the fever is certainly not shortened by antipyrine. On the other hand, after the bath the patient felt much better; he was brighter, he called for food, and fell asleep to awake much refreshed, with moist tongue, cool skin, and good heart action. I have seen cases where all the signs of hypostatic congestion of the lungs have cleared up after the use of the cold bath.

In eight cases antipyrine was given to lower the temperature. From forty to sixty grains, with half an ounce of whiskey, were given per rectum whenever the thermometer registered 104.4° F. In three of the cases vomiting was noticed. In one, severe chills and profuse sweating followed the administration. In all the cases the perspiration was so free that the patient's clothing was soaked through. One patient expressed himself as feeling much worse after the fall in the temperature had taken place. In the same patient the temperature fell from 106.4° to 100° in the course of an hour.

In one case no reduction of temperature followed the administration of antipyrine. Two cases in which the drug was used proved fatal.

Antifebrine was given in three cases. All the patients sweat profusely, and, in all, the pulse was decidedly weakened. In one case, which went on to a fatal termination (peritonitis case), there were marked prostration, cold bodily surface, copious perspiration, feeble pulse, and vomiting after the drug was taken. Three doses were given in two days; the first dose of five grains, and the remaining two of two grains and a half. After the five-grain dose the temperature fell from 105° to 99.8° in four hours. This patient had been bathed twice, but stood the bath badly. ●

Baths were given to nine patients. The tub was wheeled to the bedside, and the patient was lifted into it. The temperature of the water at the time of immersion was generally above 80° F., and then it was gradually reduced to 68° by means of cracked ice. In some cases the temperature of the bath was not brought down lower than 72°. The patient's temperature was taken every five minutes while he was in the bath, and as soon as the thermometer registered 102° F. he was taken out. The first effect of the submersion was to raise the body-heat a quarter of a degree

or so; but as soon as the fever began to abate it would go on decreasing gradually, so that after the patient was removed from the bath the temperature would still continue going down two or three degrees.

The duration of the baths was from twenty-five minutes to one hour and a quarter. One patient required as many as seven baths to control the temperature. In five cases the temperature did not go up above 104° after one or more baths. In two cases the temperature was not affected by the bath; in fact, in one of these cases the temperature ran up four-tenths of a degree during a bath lasting half an hour. To sum up, in seven cases the patient's condition was very much improved by bathing, in one no effect was obtained, and in another the bath did harm. The latter patient, who afterward got antifebrine, became cyanosed and chilled during the bathing. Two patients that were bathed died.—*N. Y. Med. Jour.*, April 30, 1887.

Barber (C. F.). Are Syphilitic Attacks Made More Pronounced by the Withdrawal of Alcoholic Stimulants from the Inebriate?—I have in mind several cases in which the disease was dormant for a long period, and suddenly reappeared after a prolonged debauch. In one case this was marked by a most severe laryngitis, causing loss of voice, difficulty in swallowing (to such an extent that nothing but fluids could be taken, and these only in small quantities), swelling of the tongue, and sordes upon the tongue and inner side of the cheeks. This patient retired in apparently good health, but upon awaking the next morning found himself in the condition I have described. Another case is that of a man who invariably, after one of his debauches, is the subject of a syphilitic ulcer on the anterior pillar of the fauces. A third has to combat a serpiginous ulcer over the crest of the tibia. A fatal case which came under my observation was that of a laborer who had contracted syphilis previous to a prolonged debauch, which terminated only after he had been sent to an institution for the cure of inebriety. After being restored to apparently his healthy condition, and while at work among his fellow-inebriates, he was complained of on account of a terribly offensive odor which emanated from him. This could not have been a result of neglect of cleanliness, for he was compelled to bathe frequently. Upon examination

he gave a syphilitic history, but said that he had not been troubled for some time by any manifestation of the disease. Upon the removal of his clothing there were found syphilitic papules scattered over his body, and his scrotum was found to be a complete mass of ulcers. There were also ulcers upon the inner side of each thigh. The testicles were no doubt involved, but the condition of the scrotum forbade handling, and the internal parts of the sac could not be examined. This condition had all come on within three days, as the patient had had his bath and a change of clothing, under the eye of a reliable person, but three days previous, at which time he was apparently in a perfectly healthy condition.—*N. Y. Med. Record*, May 7, 1887.

Nicholson (B.) on Coincident Vaccination and Small-pox.—The writer vaccinated three babies on the eve of their breaking out with small-pox; the following noteworthy facts occurred in all: 1. In all, the small-pox ran its modified course as after vaccination, and this though the latent small-pox must have been in the system prior to the vaccination, and though this vaccination had only in two cases commenced to run its visible course, and in a third case had not even done this. 2. As by modified course it is meant that there was no exacerbation on the eighth day, but that the disease practically declined on that day, and there was no formation of pus, there was, therefore, no symptom of danger nor cause of anxiety throughout. 3. Except the vaccine scars, not a single scar was left on the bodies of these infants, nor even on their faces.—*Br. Med. Jour.*, April 30, 1887.

Granville (J. M.) on the Management of Gout.—He avoids the administration of alkaline carbonates, and insists strongly on the need of giving large quantities of fluid to "flush the kidneys" and wash out the uric acid as fast as it has been set free. This is the principle of the treatment, and to the elimination or destruction of the uric acid the attention is limited, no effort being made to restrict the supply of the material from which uric acid is formed. The theory of the method adopted is simple enough, and if it should prove as successful in general practice as the author has found it in his own, it will certainly deserve the approval, as it now manifestly claims the consideration, of the profession at large.

One point to which he directs attention will have special interest for practitioners, namely, the recognition of a form of dyspepsia accompanying the accumulation of fat, which he attributes to the discharge of pancreatic juice into the duodenum without a corresponding discharge of bile, so that the fat of the food is emulsified instead of being saponified, and the stage of digestion which immediately succeeds gastric digestion is imperfectly performed. This is new ground, and the suggestions thrown out are of a nature to give rise to discussion out of which good may come. The part played by the pancreas in digestion, much as it has engaged the attention of physiologists, has not yet commanded the consideration its importance demands.—*Edit., Med. Press and Circ., March 30, 1887.*

TOXICOLOGY.

Fatal Cases of Camphor-Poisoning.—Dr. Mary J. Finley prefaces the report of her own case by stating that she has been able to find reports of but two cases in which death was presumably due to an overdose of camphor. One was in a feeble infant, to whom thirty grains of powdered camphor had been given as a vermifuge. The second case was that of a woman, forty-six years of age, who took 184 grain in order to produce abortion. The abortion was produced and the patient died. The smallest dose known to have produced alarming symptoms in an adult is 20 grains; the largest dose recovered from is 160 grains. The following is the case reported¹ by Dr. Finley: "On August 5, 1886, I was called to see a child, aged two years, and found it in violent convulsions. About an hour before that time the mother had heard it crying in the adjoining room, and the child met her in the door, crying that its mouth was burned. A bottle which had contained an alcoholic solution of camphor lay on the floor; some of the liquid was spilled on the carpet, and the front of the child's dress was saturated with it. After taking a drink of water and having its mouth washed, the child made no further complaint, and appeared to be perfectly well. But in about half an hour it suddenly fell over in its mother's arms, apparently unconscious. It remained quiet for a while when convulsive movements began, slight

at first, but increasing in violence until I saw it. At that time the breathing was noisy and rapid; pulse 180, but not weak; skin moist and pale, but warm. The breath smelled strongly of camphor. I immediately ordered a warm bath, and while that was being prepared gave an enema of bromide of potassium and chloral. While the patient was in the bath the convulsive movements moderated, until there was only a spasmodic jerk of the right arm and side of the chest at intervals of several seconds; this was accompanied by spasm of the diaphragm. In half an hour the convulsions again became general, and the hot bath was repeated; bromide was again given in strong coffee by enema. The movements moderated as before, and finally ceased. Two and a half hours after the ingestion of the poison the child was comatose; breathing slightly stertorous, but normal in rapidity; pulse 100 and of good strength; skin natural in color, warm, and free from moisture. At this time Dr. A. J. Erwin saw the case with me. The child looked as though it was in a natural sleep; and from all previous experience with camphor-poisoning, and from the teaching on the subject, there was every reason to expect that the coma would pass into that condition, and the child would awake convalescent. But in less than an hour the convulsions returned with redoubled fury, and continued unabated until the little fellow expired. Death occurred in about four hours from the time the camphor was taken. The temperature during the final convulsion ran up rapidly. Immediately after death there was a free watery evacuation of, apparently, the enema which had been administered, and which had not been absorbed. The attempted medication by the rectum had, in all probability, no influence whatever on the course of the symptoms. The child could not swallow at any time after I saw it. I was told that it had vomited before my arrival, but the mother afterward informed me that it had not done so. The amount of camphor taken cannot be known with certainty. It is strongly probable that the child did swallow more than a drachm of the solution; if so, death occurred from 15 grains of camphor."

Richard Davies reports² a similar case.—"About 3 P.M. on December 7, 1886, a message came for me to see a child who had

¹ *N. Y. Med. Record*, Jan. 29, 1887.

² *Br. Med. Jour.*, April 2, 1887.

eaten a piece of solid camphor. In my absence, my assistant went at once. He found a female child, aged two years and eight months, in its mother's arms, pale, with blue lips, a very rapid pulse, and having severe convulsions. He irritated the fauces with his finger, which caused vomiting, and an emetic which was administered also caused vomiting. The vomit was partially digested food, smelling strongly of camphor. I soon after saw the case. The child has recovered somewhat from its collapse, but was still having convulsions, and in the intervals was semi-comatose. I obtained a stomach-pump, and washed out the stomach with warm water; the water which came back smelt strongly of camphor. This for a time seemed to check the convulsions, and I left. At 8, I saw the child again, and gave a dose of castor-oil, and ordered three grains of bromide of potassium every three hours. At 10 o'clock the child was no better, and so continued in convulsions all night, and succumbed to them at a quarter to nine on December 8th, eighteen hours after having taken the camphor. The difficulty in treating the case was that the camphor had been taken in a solid form, and its insoluble nature prevented the stomach-pump acting on it in any useful way. I think that the public have no idea of the dangerous nature of the drug, especially to children. It is, as this case proves, fatal in comparatively small doses. The mother said the piece was about as big as a nut (say, half a drachm)."

Fisk (S. A.) on a Case of Attempted Suicide from the Ingestion of Thirty-six Grains of Morphia, Which Remained in the Stomach Five Hours.¹—William P., aged thirty-eight years, a German, six feet in height, about two hundred pounds in weight and of powerful build, becoming tired of life attempted suicide by taking 36 grains of the sulphate of morphia at ten o'clock on the night of March 6, 1887. He also opened a small vial of the spirits of chloroform, that he had with him, and drank a fluid drachm. When he reached his house and got out of the hack, the driver thought he was drunk. P— afterwards stated that the last thing that he remembered was his getting into bed on reaching home. He drank freely of water,

and, on the arrival of the woman with whom he had quarrelled, he was given a couple of glasses of milk, and a physician was summoned.

Two and one half hours after the ingestion of the drug, respirations were 6 per minute; pulse sixty-eight. Pupils pin-hole. Patient cyanotic. Ten grains of tartar emetic were placed upon the tongue and an attempt was made to wash it down, but the reflex effort of swallowing could not be excited. The attempt and the dose were repeated, with a like effect, in about twenty minutes. Twenty minims of the fluid extract of belladonna were given hypodermically at 12.30 A. M., and the dose was repeated at 12.45, and again at 1.15.

Three and one quarter hours after ingestion of the drug, we immediately applied the galvanic current from eighteen cells, the negative pole being placed over the right superior carotid triangle, the positive over the præcordium, and the current interrupted very slowly. Galvanism and the belladonna brought up the respirations, both in depth and number.

Four hours after ingestion, one sixth grain of apomorphia was given hypodermically, and was repeated in about twenty minutes after the first injection, and followed in twenty minutes more by a third injection, making one half grain in all of the drug that was given hypodermically, but it was of no avail.

Five hours after ingestion, galvanism having been kept up pretty constantly, an œsophageal tube was introduced into the stomach and it was thoroughly emptied and washed. The citrate of caffeine, grains fifteen, in solution, was then administered by the tube and the tube withdrawn. At this point the respirations ceased, the heart stopped beating and could not be heard over the præcordial region. The face and surface of the body became pallid, and we were afraid that life had flown.

Galvanism from eighteen cells was applied as before, and after three or four minutes a shallow inspiration occurred, and a second, and a third. Electricity was continued, the expirations were increased by compressing the chest, the heart started beating again, the respirations were restored, and the patient broke out into a profuse cold sweat.

¹ The Editor recently had a patient take 18 grains of morphine in powder with suicidal intent. Emesis

did not occur until 5 hours after ingestion. No bad results followed except a mild gastritis.

Six hours after ingestion, the stomach tube was introduced a second time and fifteen grains more of caffeine administered. On withdrawing the tube the pulse and respirations stopped as before, and were reproduced by galvanism as described. The respirations soon became Cheyne-Stokes in character, four or five series to the minute, and from that time for several hours but little was done except to stimulate the inspirations with a weak galvanic current whenever they seemed to flag.

Eleven hours after ingestion: respirations eighteen per minute and fairly regular; pulse one hundred; patient unconscious.

Thirteen hours after ingestion, gave strong coffee, by spoonfuls between the cheek and the teeth, some of which would be drawn into the trachea and produce a violent coughing, and the patient would thus become partially aroused, but dropped off instantly into slumber again. Could arouse him and make him cross for an instant or two, by pulling his beard. Slapping the face with a wet towel produced contractions of the orbicularis palpebrarum and corrugator supercilii. The citrate of caffeine in six-grain doses was administered every two hours for four or five doses, and we kept pouring down black coffee by spoonfuls and by arousing patient enough for him to drink a little.

Seventeen hours after ingestion, vomited a little. Could be aroused sufficiently to be made to walk, supported by a man on either side. Pulse one hundred and twenty, and thready. Respirations normal. Very drowsy, but could be kept from going into a deep sleep by talking to him. Skin bathed in perspiration.

Twenty hours after ingestion, sufficiently conscious to answer questions intelligently. Voice very husky, and he complained of his throat hurting him. That night he vomited profusely and repeatedly.

The subsequent history was marked by great physical prostration; by a sore throat, on which some sloughing patches occurred; and by a cough, which with the ulceration in the pharynx lasted about ten days. At the end of that time he was able to get up and be around, and to-day he is a well man.—*Boston Med. & Surg. Jour.*, May 12, 1887.

Blackmon (J. D.) on Opium-Poisoning.—I was present when a lady, by mistake, gave a child ten months of age,

one eighth grain of morphia, or perhaps more. It was a large dose for an adult. In about fifteen minutes, the child was in a deep state of coma, when the lady discovered her mistake and immediately informed me as I was sitting at the breakfast table. I at once went to the child, and found it could not be aroused; tried to administer an emetic, but the child could not swallow. I felt baffled, but thought I must do something, so I ordered about two gallons of very strong coffee to be prepared, which was done in a few minutes. I then immersed the child in the coffee, keeping it in the bath about five minutes; repeated in about fifteen minutes, when the child opened its eyes, and I got it to swallow a little strong coffee. It would relapse into coma at intervals, but not get past swallowing. I continued to give coffee internally, also to bathe with same, and aided the little patient with artificial breathing. In about twelve hours the child recovered.—*Med. Brief*, May, 1887.

Kiernan (J. G.) on Capsicum in Opium-Poisoning.—One of the most important uses of capsicum has generally passed unnoticed. It is of decided value in the treatment of opium-poisoning. In the suggestion of its use in opium poisoning, I can claim originality, but not priority. Dr. C. H. Hughes was the first to use capsicum enemata in the treatment of opium-poisoning. His case was as follows: A patient had taken opium with suicidal intent. Dr. Hughes being called in after atropine and the usual routine remedies had been tried, ordered an enema of one drachm each of aqua ammonia and tincture of capsicum, using coffee as a vehicle. The patient made a complete recovery.

In 1881 I was called to a case with the following history: A patient, suffering from the insomnia resulting from a prolonged debauch, purchased two ounces of laudanum and swallowed one. Within half an hour he sank into a deep slumber. Dr. E. C. Dudley was called, who, by means of the stomach-pump, relieved the patient of about half the laudanum taken. Dr. Dudley found that, despite the use of strong coffee and constant movement, the patient did not improve. He then called Dr. Jewell in consultation, who advised the use of atropine. Under all these varied means of treatment there were temporary rallies, but after six hours of constant treatment the patient seemed to sink into and remain in

a deep coma. At this stage I was called in consultation, and having some faith in the old theory of derivation, ordered three drachms of tincture of capsicum to be poured directly into the rectum. The effect was almost magical. The patient walked around briskly, talked freely, and in about an hour was in his usual condition, other than being much exhausted and suffering from great dryness of the throat obviously the result of atropine."

The report of three similar cases similarly treated follows, the result in all being a rapid and perfect recovery.—*Med. Standard*, Feb., 1887.

Belfield (W. T.) on the Mimicry of Opium-Poisoning by Meningeal Tuberculosis.—The case was that of a girl about twenty years old who had always had excellent health. Three sisters are still living, and neither they, the parents, nor any of the relatives, so far as known, have ever shown symptoms of tuberculosis. The present generation are examples of perfect health, and this girl was in many respects seemingly the healthiest of the lot.

Until five days before her death her health was as usual; then she complained of feeling ill one evening; her head ached; she vomited without apparent cause; she lay down, drank a cup of tea, and was all right. The same thing happened the next day, and she complained of extreme headache. On the third day, with the exception of severe headache and seemingly causeless vomiting, she remained in her usual health. The evening before her death she was at the theatre, and came home about eleven o'clock, going to bed with one of her sisters. During the night the sister was several times awakened by the extraordinary breathing of the patient, which was very hard and loud. She shook her and the abnormal breathing ceased. In the morning it was found impossible to awaken her: she was breathing very deeply and slowly and could not be roused.

Physicians were summoned and all of them pronounced it a case of opium-poisoning. The symptoms observed were stertorous breathing, sometimes as slow as four or five per minute, contracted pupils, a suggestion of strabismus, and rather warm surface. The pulse was remarkably good, about 80, similar to the pulse of a healthy person; the skin was not moist and clammy. The usual measures for opium-poison-

ing were adopted. Mustard was given at once, and as soon as a tube could be procured the stomach was pumped out. Minute doses of atropine were injected hypodermically, the patient receiving about a fortieth of a grain in three injections. The breathing improved very much after these injections, coming up to twelve and fifteen per minute; the pulse also quickened; suddenly the pulse flickered and went out and the breathing stopped.

On the following day the assistant county physician, Dr. Krost, and myself made a post-mortem examination, of the head and abdomen. The brain was not hyperæmic, there was no venous congestion, the pupils were widely dilated; the membranes of the brain were adherent to the brain substance, and on stripping close they were found on close examination to be studded with numerous miliary tubercles. On opening the abdominal cavity the intestines bulged out, and their surface was thickly studded with miliary tubercles. There was extreme tuberculosis of the peritoneum. The mesenteric glands were large and cheesy. The right ovary contained a ruptured cyst about as large as a fist. That the rupture was ante-mortem was evident from the fact that the inner surface of the cyst was intensely congested and there was a good deal of coagulated blood in its cavity.—*Medical Standard*, April, 1887.

Fairbrother (H. C.) on Poisoning from Strong Ammonia.—On the 23d day of December last, while a large number of workmen were engaged in the construction of a freezing machine in a large brewery in this city, some timbers gave way and the men and machinery were precipitated to the floor of the engine-room, about twenty feet below. In the crash which followed there was broken open a large vat containing a strong solution of the anhydrous liquid ammonia. This fluid rapidly spread over the entire floor of the room, and within a few seconds filled it completely with its dense fumes. Four men, Kieffer, Burke, Turner, and Bevelot were confined within this room for a period of about three minutes before their exit could be effected. When removed, their condition and subsequent history were as follows: Kieffer was utterly unconscious, in a comatose condition, with heart-beat scarcely perceptible. He died within a quarter of an hour. His entire body was drenched with the solution, and

the exposed portions, as the face and hands, were deeply blistered. The tongue and pharynx were also denuded of their mucous membrane, the fluid having been taken into the mouth after he was prostrated by the fumes. Burke was found in a condition very much like that of chloroform excitement. He was unconscious, unable to stand erect, and in wild delirium. He was carried to his room, placed in bed, and half a grain of sulphate of morphia given hypodermically. The heart-beat and respiratory movement were both very disturbed. There was no marked change in his condition for a period of two hours, when he suddenly expired. Turner was entirely conscious and able to walk about. He was removed to his home, some blocks away, and placed in a comfortable position. He complained of occasional difficult breathing, and preferred the erect posture in the bed. He could swallow readily and converse easily. About five hours after the accident, however, the dyspnoea suddenly increased, and after two or three times gasping for breath, he died. Bevelot, who received a compound fracture of the leg in the fall, has had a long period of suffering. On account of sloughing, the leg was amputated. He is now convalescent, but he has suffered, during this entire time of nearly three months, from a bronchial irritation, which produced an almost continuous coughing. He has also suffered from frequent hæmoptysis, and is partially paralytic on the right side.

The cause of death in the three cases was given as "heart failure, resulting from bronchial congestion; this being caused by inhalation of ammoniacal gas."—*St. Louis Med. and Surg. Jour.*, May, 1887.

Henderson (R. B.) on a Case of Poisoning from Antipyrine.—A girl ten years of age was first seen on October 7th, and was found to be suffering from remittent malarial fever, having a temperature of 104° F. About three grains of antipyrine were given, and sulphate of quinine was ordered for the next day. On the 13th, tincture of nux vomica was ordered to be given, in three-drop doses, three times a day. She was seen again, two days later, and was found to be doing well, although she had been restless at night. The temperature was 102° F. Thirty grains of antipyrine were ordered to be given, in two doses, at two hours' interval. A few hours later the uncle of the patient

called, and asked what had been left for the child to take. He was told what the drug was, and said: "Well, sir, it killed her in fifteen minutes." Dr. Henderson went with him, and found his patient really dead. He was informed that the medicine had caused an intense burning in the throat and stomach, and that the patient had vomited a watery fluid, then fainted, and was dead. There were no convulsions nor any thing to indicate that nux vomica had caused the death. The family said that the child had at times complained of palpitation of the heart, and they all thought she died from heart disease. This was also the conclusion of the writer, but it was modified considerably by the occurrence of a second similar case.—*Med. Brief*, May, 1887.

Sinclair (A. J.) on a Case of Phosphorus-Poisoning.—The following case may prove of interest as showing the prolonged latent period before the exhibition of fatal symptoms of poisoning by phosphorus:

I was hastily summoned at 1.30 P.M., on a Monday of 1883, to a child suffering from severe clonic convulsions, trismus, and opisthotonus. A dark treacle-like fluid was occasionally vomited. The pulse was extremely rapid, but of fair volume; the cheeks presented a red, flushed appearance; eyes were preternaturally bright, with pupils somewhat contracted. The child was 22 months old, and had a healthy, plump appearance.

On the Saturday previous, at 9 A.M., she partook of a hearty meal of porridge and milk, and at 11 A.M. was left sleeping in the bedroom. Three hours after she was found with mouth and lips covered with a red substance, which was seen to proceed from the heads of a number of matches lying beside her. The number computed to have been sucked were from one dozen and a half to two dozen. The white of an egg with flour was at once administered by the relatives, which caused white-colored fumes to proceed from the mouth. Two teaspoonfuls of syrup of senna were administered, which acted freely in the evening, but nothing unusual was observed in the character of the motions. She went to bed apparently well, slept soundly, and partook of her ordinary food. On Sunday nothing unusual was observed beyond her body being somewhat cold and her having an abnormal thirst. The night was passed restlessly. At 8.30 A.M. her face was observed to become of a

bluish-red color and her body cold, but, being apparently quietly sleeping, she was not disturbed. At 12 noon a scream was heard, and on the relatives rushing into the room she was found unconscious, and in the state described in my previous context. She was placed in a warm bath pending my arrival without any appreciable benefit. The tetanic spasms occurred at intervals of five minutes. On my arrival I gave chloroform freely, with the effect of prolonging the interval. I then washed out the stomach, and gave $\frac{3}{4}$ ss turpentine injection. Shortly after this the convulsions ceased, and she sank into what seemed a deep sleep, breathing regularly and quietly. The pupils were somewhat more dilated. I then left her, and on again seeing her at 7.30 P.M. this deep sleep had continued. The extremities and whole surface of the body were warm. A bright flush remained on her cheeks. I had not been present twenty minutes when her lips and cheeks became suddenly blue, and after one or two sighs her respiration stopped, and simultaneously her heart ceased to beat.

The body remained warm for some hours after death. I may add that the evacuation produced by the enema showed no signs of phosphorescence, nor did the vomited matter, which consisted of altered blood from gastric mucous membrane. No post-mortem examination was permitted.

I find that each box contains one hundred matches, and is made with one grain of phosphorus. The amount taken was, therefore, under one fourth of a grain.—*Edin. Med. Four.*, March, 1887.

Brothers (A.) on Poisoning from Eggs.—On April 16th the family of Mr. S.—had supper at 7 P.M. The meal consisted principally of eggs which had been boiled that morning and allowed to remain all day in the warm kitchen. Although it was noticed at the time that the eggs had a bad odor, still they were eaten by the father and four of the children, ranging between two and twelve years of age. The mother and the remaining two boys did not partake of them. Within an hour every one of the five who had eaten the eggs became sick. I was sent for at 11 P.M. and found them suffering from symptoms evidently due to acute irritant poisoning. Prostration was very marked. Retching was present, and there was frequent vomiting. The matter vomited consisted of bad-smelling food and mucus,

strongly tinged in one case with blood. Cramps referred to the stomach caused several of the children to cry out from time to time with pain. Thirst was extreme, but the water taken to quench it at once excited vomiting. Diarrhœa, with yellow watery movements having a strong odor of rotten eggs, was present in all cases. Stupor with a desire to be left alone, was also a prominent symptom. After a while the father and two of the children passed into a condition of collapse, and it looked as if they might die at any moment. They lay with the eyes half closed, showing the whites of the eyeballs. The pupils in some were contracted, in others dilated. The extremities were cold and the skin was covered with a clammy sweat. The pulse in the father was about 70, but extremely soft and compressible, and at one time almost imperceptible. In the children the pulse ranged between 120 and 180. The temperature in most of the cases was subnormal. After several hours, improvement set in, and next day they were all out of danger. In the treatment of the cases I was assisted by Dr. J. Horn. After emptying the stomach by the use of sulphate of zinc and washing out the stomach in one of the older children, calomel in mucilage was given to clean out the intestinal tract. For the vomiting occurring after this and also to quench the burning thirst, ice proved to be of great service. When the cases passed into a condition of collapse, heat was applied to the extremities, tablets of digitalin were given by the mouth, and brandy was administered hypodermatically.—*N. Y. Med. Record*, May 14, 1887.

Church (H. M.) on a Case of Poisoning by Corrosive Sublimate.—On May 7th, about 4 P.M., A. B., aged 5 years and 3 months, had administered to her a dessertspoonful of glycerine containing about 10 grains of corrosive sublimate. The spoon was put well to the back of the tongue, and emptied. The child, discovering the error, rejected at once what she could of the exceedingly acid substance, but seems to have swallowed about one-half. From the mother's statements it appears that violent vomiting came on immediately, and that the stomach was largely emptied of its contents; this was followed by constant retching of mucus, which soon became tinged with blood. The bowels had also acted once or twice.

Four hours after swallowing the poison, when first seen by me, she had a pale ashy-colored face, with very anxious expression. She had swelling of the lips and cheek, complained of pain in the throat and in the pit of the stomach, to which she frequently put her hand, and continued retching small quantities of mucus brightly tinged with blood. She asked constantly for water, and swallowed freely milk and white of egg. Pulse 108, fairly strong. Till 1 A.M., she remained much in the same state, and then fell into a drowsy condition till 5 A.M., when retching and purging came on. About 6 A.M. she got up, walked across the floor, put her mouth to the water tap and drank freely during the temporary absence of her mother from the room. She fell again into a drowsy state for about an hour and a half, and then the previous symptoms returned with great virulence. At 10 A.M., her pulse was 180, very weak; respirations, 64; temperature in axilla, $105^{\circ}.6$, and in the rectum, $106^{\circ}.6$. During the night she had taken milk and the albumen of eight eggs. She seemed free from pain, but had terrors, such as a stone wall about to fall upon her, people coming to take her away, etc., also incoherent muttering about her playthings. The pupils were widely dilated and insensible to light. The most striking feature was a constant twitching of the eyelids and eyeballs, the latter being rotated upwards and kept upwards in a jerky manner. The fingers scratched rather than picked the bedclothes, and every few minutes twitchings and tremblings of the whole body occurred, and at longer intervals violent startings. There was no salivation, but profuse mucous discharge from the nose. A little bloody mucus was occasionally discharged from the bowel. There was complete suppression of urine. Her mother states that she continued much in the same condition, with the eyes jerkingly fixed on the corner of the ceiling, till about 2 P.M., when she said, "I am dying," and in three minutes expired, exactly twenty-two hours after taking the poison.

An autopsy was made twenty-three hours after death, with the following results:—Lips livid; gums white; sordes on upper incisors; post-mortem rigidity well marked; features placid. Upon exposing the abdominal contents, the portion of the stomach visible was of a bluish-gray appearance. The right auricle of the

heart was distended with blood for the most part fluid. The tongue was sodden, and the pharynx presented a general diphtheritic look. The gullet was distended. Kidneys congested; bladder empty.

In the duodenum there was no trace of congestion. The small intestines contained a good deal of flatus, presented no marked state of congestion, but there was a grayish-yellow appearance of the mucous membrane throughout. In the lower part of the bowel the mucous membrane was more of a greenish color. The cæcum had feculent contents, but was not congested. The transverse and descending colons were markedly contracted, but with the exception of a patch of congestion, about the size of a florin, in the sigmoid flexure, the mucous membrane of the large intestine was pale and apparently normal.

Upon examination of the *removed* parts, the stomach was found to be discolored along its smaller curvature, the larger curvature being comparatively unstained. When opened along its lesser curvature, there stretched from the pylorus along the curvature a band, three inches in breadth, of intense congestion, of port-wine color. The congestion stretched down in small curves towards the lower curvature. The rest of the stomach presented a yellowish-gray appearance. No abrasion of mucous membrane could be discovered, but along the larger curvature the mucous membrane appeared thin and diaphanous. The discoloration surrounded the entire cardiac end of the stomach, and abruptly terminated towards the œsophagus by a well-marked line of slight congestion. To within 1 inch of its upper extremity the œsophagus also presented a yellowish-gray appearance. Above this there was marked congestion, which became intense over each tonsil, on the epiglottis, and on either side of the rima glottidis. Gray patches of a diphtheritic nature covered the fauces. The trachea was markedly, and the larynx moderately, congested.

Seven specimens were removed from the body for chemical analysis, viz., the mucus from the nasal cavity, the contents of the stomach, the contents of the duodenum, the serum removed from the pleural cavity, the ejecta from the bowels six hours before death, a portion of the liver and one kidney, with the remarkable result that not a trace of mercury could be detected.—*Edin. Med. Jour.*, March, 1887.

DISEASES OF THE NOSE AND THROAT.

ABSTRACTS AND SELECTIONS BY C. H. KNIGHT, M.D.

Erysipelas of the Upper Air Passages.—In addition to the two cases reported by him at a meeting of the American Laryngological Association, in 1885, Dr. D. B. Delavan narrates the clinical history of a third example of this rare lesion. The patient was a stone-cutter, forty-seven years of age, who had an attack of facial erysipelas fourteen years ago. The present attack involved the face and scalp, and was attended by grave constitutional disturbance. On the thirteenth day, external symptoms having begun to subside, the patient was attacked with pain in the pharynx and dysphagia, whereupon the inflammation extended to the nasal cavities, the upper pharynx, the faucial region, the larynx, the mouth, and the adjacent glands. Ten days later an abscess of the pharynx was incised and about one ounce and a half of dark, bloody serum evacuated. From this time until about the fourteenth day of the disease the condition of things gradually became more serious. The treatment consisted of thorough spraying of the nose and pharynx with alkaline and antiseptic solutions, inhalations of benzoated steam every half hour, a spray of a solution of chloride of zinc, three grains to the ounce, every hour, tincture of the chloride of iron, fifteen drops every two hours, sulphate of quinine, two grains every six hours, and abundant nourishment. The disease resulted in recovery after an entire duration of about four weeks.—*N. Y. Med. Record*, April 23, 1887.

In the *Medical Register*, March 16, 1887, Dr. E. E. Wells reports a case of erysipelas of the pharynx, in which the external manifestations were secondary in importance as well as regards time of appearance. The patient was a woman, thirty-two years of age, who had taken charge of a severe case of erysipelas one week before her own throat symptoms began. Cutaneous symptoms, which made the diagnosis clear, were developed forty-eight hours after the sore-throat. This case lasted not more than ten days.

In the *St. Louis Cour. Med.*, April, 1887, Dr. J. T. Davis gives the history of a case of facial erysipelas, which involved the

throat on the fourth day. This case occurred in a man, forty-five years of age, and ran its course in about two weeks. Relief to the throat symptoms was obtained from the use of steam inhalations, applications to the pharynx of solutions of nitrate of silver, and internally tincture of the chloride of iron and quinine.

In the *Am. Practitioner and News*, April 30, 1887, Dr. J. M. Harwood reports an interesting case of erysipelas of the nose, involving the upper air passages, and accompanied by hemorrhage from the bowels. The affection began in the form of what was supposed to be a boil within the left nostril. Although the temperature but once rose above 100° there was extreme prostration. The intestinal hemorrhage persisted for more than a week, on three occasions being profuse. In the writer's opinion the disease was transmitted along the alimentary canal, and was not a metastasis. He has been able to find only one similar case, that reported by Bayer in Ziemssen's *Cyclopedia*.

Some General Rules which will Determine the Necessity of an Operation in the Nasal Passages.—In the *Buffalo Med. and Surg. Journal*, May, 1887, Dr. F. H. Potter suggests the observance of the following rules in the treatment of the nasal tract. All causes of irritation must be removed, the most offending one first if possible. Encroachment upon the normal breathing space must be relieved. Finally, it is important to secure proper drainage of the nasal passages. The author disagrees with Bosworth, who has made the assertion that all deflections and deformities of the nasal septum are due to injury. Acknowledging the importance of traumatism as a causative factor, he believes that the conformation of the interior of the nose, as well as its external contour, is influenced by the law of heredity—that is to say, a man may inherit a deflected septum as well as a "snub nose."

A Case of Naso-Pharyngeal Growth.—A very interesting case, illustrating a rather extraordinary accident, was reported by Dr. Samuel Johnston at the meeting of the American Laryngological Association, in 1886. The case was one of fibroma, in a boy of twelve years, nearly filling the naso-pharynx, and completely occluding the right posterior naris. In attempting to remove the growth, under cocaine, by means of the cold wire snare, the

shaft of the *écraseur* broke near its tip. The fragment of the instrument could not be withdrawn through the anterior naris. The patient becoming restless, it was decided to desist from further interference, after failure of an attempt with a second *écraseur*, in the hope that the growth would slough off. Four days later the snare was again applied and the base of the tumor cut through without much difficulty. The fragment of the *écraseur*, measuring eighteen millimetres in length and about two millimetres in diameter at the point of fracture, came out through the mouth. The tumor was firmly impacted, and was removed with forceps through the mouth, not until six hours later. It measured an inch and a half by one inch. There was but little hemorrhage. — *N. Y. Med. Jour.*, April 23, 1887.

Therapeutics of the Upper Air Passages.—At a meeting the N. Y. Academy of Medicine, April 21, 1887, several papers were read upon the above subject. Dr. Bosworth mentioned that chronic laryngitis is coming to be regarded as not necessarily tubercular or specific in character, but often merely secondary to affections of the regions above. Applications to the oropharynx, which is a part of the food track, do no good whatever. Disease of the vault of the pharynx, characterized, not by excessive secretion, as popularly supposed, but by diminished and perverted secretion, does not require astringent applications. Nasal catarrh is not a hyper-secretion to be cured by astringents. Sprays are useful as cleansing and palliative, but the curative treatment consists in removing obstructive lesions giving rise to nasal stenosis. This is to be accomplished by means of the snare, the saw, the knife, or the cautery. The speaker expressed a decided preference for chromic acid over the galvano-cautery. He seems to consider cocaine a specific in acute catarrhal rhinitis. Dr. H. H. Curtis was even more extravagant in praise of chromic acid as a caustic. Dr. A. H. Smith was very doubtful of the efficacy of topical applications in chronic catarrh except as thorough cleansing may be palliative; acute exacerbations may generally be benefited by sedatives and astringents. Hygienic measures, and in some cases internal treatment, are also of value. Dr. W. H. Thomson called attention to two principles upon which the treatment of disease of the upper air passages should be based. First, the re-

lation of the cutaneous nerves to the diseased condition, and, second, local disinfection. In connection with the former the external use of cold was referred to. With regard to disinfectants, those of the carbolic acid class are to be chosen for the suppurative disorders. For necrotic affections, remedies of the chlorine group are superior. Dr. Jarvis announced his preference for rhigolene over cocaine in many cases. Sprays are to be recommended, powders condemned, only one, iodoform, being tolerated by the upper air passages. Chromic acid should never be used for turbinated hypertrophy. It is slow and not entirely safe. More can be done with less danger and more quickly by means of the transfixion needle and the small *écraseur*. In atrophic rhinitis much may be accomplished in the way of relief by means of thorough cleansing and sprays of vaseline. — *Med. Record*, N. Y., April 30, 1887; and *Med. News*, Phila., April 30, 1887.

Rhigolene and Oil as a Vehicle for Sprays.—Oil is far less irritating to the nose and throat than combinations having water for a basis. The addition of glycerine or honey does not wholly overcome the irritating effect of water, while these substances impede its passage through the atomizer. Moreover, water collects and condenses too readily, hence the difficulty of thoroughly spraying the larynx. The objection to olive oil or almond oil, that they require higher pressure to be atomized, has been removed by Dr. A. Stabler by adding rhigolene in the proportion of two drachms to six drachms of oil. A fine and permanent spray, requiring no more pressure than water, may be thus produced. Essential oils and turpentine may be added to this mixture if desired. It will dissolve about three per cent. of resorcin. Astringents and cocaine are not soluble in it, but the latter may be dissolved in alcohol and then mixed with castor oil and rhigolene, while iodo-tannin may be prepared as follows:

Take a saturated tincture of iodine and dissolve in it as much tannin as it will hold. This will mix with castor oil in any proportion, and the mixture may be thinned with rhigolene to the desired consistence. It makes a very handsome, clear red solution, and though slightly irritating, is not excessively so, and the irritation very rapidly subsides. — *Med. News*, April 16, 1887.

Terebene in Chronic Rhinitis.—Dr. Isaac Barton reports good results from the internal use of terebene given in doses of three drops, increased by weekly addition of a drop until six drops have been reached, on loaf sugar three times a day. The method of preparation of the drug is described, much of the terebene in the market being impure. Locally it is of no use, and in fact is rather irritating. If hypertrophy be present, terebene is of but little use, surgical measures being then required.—*The Medical Register*, May 11, 1887.

Mouth-Breathing and its Treatment.—Dr. N. R. Gordon proposes to correct the *habit* of mouth-breathing, which may be associated with nasal disease and which may persist after relief of nasal stenosis, by the use of a celluloid shield fitted between the teeth and the lips. It is said to be retained without bandage or other appliance and to be worn during sleep without apparent discomfort.—*Jour. Am. Med. Ass'n*, April 23, 1887.

Coal Gas as a Cause of Sore-Throat.—At a meeting of the Society of Medical Officers of Health, Prof. Corfield related a series of cases in which impairment of health seems to have followed the escape of coal gas into sleeping-rooms through defective gas fittings. For several years his attention has been drawn to cases of relaxed and even ulcerated sore-throat occurring under these circumstances in houses whose sanitary condition was otherwise perfect. He pointed out that coal gas may get into houses through the basement, the floor, up through the walls, and from defective mains in the streets. The bisulphide of carbon and other sulphur compounds are believed to be the effective agents in producing the throat irritation. Some of the cases are remarkable and conclusive.—*London Lancet*, April 23, 1887.

In commenting editorially upon Prof. Corfield's report, the *Lancet* remarks that throat illness generally attributed to defective drainage may arise from other causes. There is need of more thorough investigation of local causes affecting health. Greater service may be rendered by seeking in the first instance the cause of disease, than by effecting improvement in only one of many possibly unhealthy conditions.

Quinsy.—At a meeting of the Cambridge Medical Society Dr. Easly read a paper on the treatment of quinsy, in which

he recommended aconite given by Ringier's method. Speedy relief may be obtained from ten to fifteen grains of salicylic acid or salicylate of soda given every two hours. Gargles are useless and painful. Insufflations to the swollen tonsils of tannin and iodoform, equal parts, give great relief.—*London Lancet*, April 9, 1887.

A Case of Phlegmonous (?) Sore-Throat with Œdema of the Soft Palate and Half Arches.—An interesting and rather unusual case is reported by Dr. M. J. Stern. The affection seems to have begun as a tonsillitis, chiefly of the right side. On the fourth day acute œdema of the soft palate supervened and the patient was threatened with asphyxia. The question of tracheotomy was considered, but finally the swelling was scarified and a moderate degree of relief followed. Three hours later, the swelling not having subsided sufficiently to give the patient complete relief, a free incision, about two inches long, was made. Steam inhalations of benzoin and paragoric were ordered, which proved grateful. Bleeding was very profuse, and to this fact is ascribed the speedy improvement of the case. It is the opinion of the writer that local bloodletting, which by some is thought to be contra-indicated, must be done in large quantities to be of benefit.—*The Medical Register*, April 16, 1887.

Alarming Hemorrhage after Tonsillar Excision Arrested by Torsion of the Artery.—Dr. Clinton Wagner reported a case at the eighth Congress of the American Laryngological Ass'n, the hemorrhage coming from either the tonsillar branch of the facial or the largest pharyngeal branch of the ascending pharyngeal. The patient was a female about thirty years of age. The source of hemorrhage, which was discovered by forcible depression of the tongue, was without much difficulty caught with an artery forceps and twisted. No further bleeding occurred.—*N. Y. Med. Jour.*, April 16, 1887.

Tracheotomy.—Mr. Walter Whitehead offers the following suggestions regarding the method of performing tracheotomy. The head of the patient being bent well back over a pillow, an incision is made in the usual situation, but of rather greater length than is common. The incision extends through the skin and fascia, as deep as the interval between the sternohyoid muscles. The scalpel is now laid aside,

and the raspatory used, not only to separate the sternohyoids, but to split the strong fascia which runs down from the hyoid bone to enclose the isthmus of the thyroid gland. This fascia is split to a distance extending from the upper limit of the incision down to the isthmus below—that is, supposing it is desired to open the trachea above the isthmus. The split fascia is then pushed to right and left with the raspatory. Should there be any difficulty in doing this, the fascia is separated to some extent on each side from the upper border of the isthmus. Proceeding carefully, the isthmus itself can be pushed down and the trachea exposed to the necessary extent. If the trachea is to be opened below the isthmus we proceed in a similar manner, remembering that here, however, we have between the fascia and the trachea a quantity of areolar tissue in which lies the inferior thyroid plexus of veins. The front of the trachea can in this way be cleared perfectly, and, since the method is bloodless, the rings of the tube are seen glistening white at the bottom of the wound. The trachea can now be fixed readily between the left index finger and thumb, and opened to the desired extent. There is little or no difficulty in introducing the cannula, since the trachea can be so steadily fixed and the incision into it so clearly seen.

The above method resembles in many particulars the "bloodless" method of Bose, but in the latter operation the scalpel is used to a much greater extent than in the operation here advocated, and when the scalpel is not to be used the use of the director is advised. What is urged in favour of the operation is—firstly, the ease with which it can be performed; secondly, the small number of instruments required; and, thirdly, the manner in which it meets the four difficulties usually enumerated—viz., of reaching the trachea, of hemorrhage, of opening the trachea, and of introducing the cannula. Again, it avoids, in an especial manner, those dangers met with when the operation is performed, as it too often is, practically in the dark, from the bleeding, and the not sufficient separation of the parts; thus it is impossible, in this operation, that the cannula should be pushed down between the trachea and the fascia lying in front of it, or that it should be thrust, as has actually happened, into the internal jugular vein.—*London Lancet*, April 30, 1887.

Difficulties in Establishing Natural Respiration after Tracheotomy.—At a meeting of the Clinical Society of London, Mr. B. Pollard referred to three cases illustrating the above subject, and drew attention to their treatment by tracheal catheterism. In the first and second cases the chief cause of obstruction was laryngeal spasm, but in the second there was also growth of granulative tissue. Both recovered, although the second had an attack of pneumonia, a piece of granulative tissue being dislodged from the region of the tracheotomy wound by the catheter and coughed up. In the third case there was genuine stricture of cords; the tracheal catheter served as a means of continuous dilatation for thirty-eight hours. In four weeks the trachea had to be reopened on account of re-adherence of the cords. Evidently the dilatation should have been employed for a longer period. In two of these cases the cricoid cartilage had been divided, and it was suggested that this method of operating might have had something to do with subsequent difficulties.—*Med. Press*, April 27, 1887.

SURGERY.

Dennis (F. S.) on the General Principles Involved in Amputation, with a Consideration of Some Points in the Technique.—There are four periods at which an amputation can be performed: 1. *Immediate*—before reaction from shock; 2. *Primary*—after reaction but before inflammation; 3. *Intermediate*—after inflammation but before suppuration; 4. *Secondary*—after suppuration is established. For all practical purposes these four periods can be reduced to the primary and secondary. As a rule, to which there is scarcely an exception, the immediate amputation should not be performed, as the patient is likely to die from shock during the operation. The double shock of the operation and of the injury is apt to kill the patient; and the shock of the injury of the limb may be complicated with shock from injury of some important internal organ from which the patient could never rally, and hence the impropriety of the amputation, and the needless addition of suffering to the patient on account of the operation.

In cases of compound comminuted fracture, with injury to the main artery of the

limb and with great loss and destruction of tissue in the soft parts, the hemorrhage is often alarming, and amputation is called for imperatively as the only salvation for the patient. What is the earliest moment a surgeon should operate? Never during profound shock; and the rule which must govern a surgeon is, to employ all known means to control hemorrhage and to bring about reaction from shock, and wait. If the patient has pallor and coldness of skin, weak and feeble pulse, sighing respiration, non-reacting pupils, traumatic delirium, internal injuries—no amputation is indicated. The earliest possible time an amputation can be performed, under great necessity from hemorrhage, is when reaction is beginning; but unless the patient is likely to become exsanguined by delay the beginning of reaction is an unfavorable period for operation, and it is wise to defer it until reaction is fully established. By means of antiseptic compresses applied tightly over the bleeding wound, and not above the wound upon sound tissue, hemorrhage can be controlled and the wound kept from rapid sepsis a sufficient time to give the patient time to react. I have seen an Esmarch elastic bandage applied above a lacerated wound, over sound tissue, and when the flaps were made a certain amount of sloughing followed from the compression. The wound itself is the proper place to apply firm compression, never above the seat of the wound. This point is one of practical importance, because the elastic bandage as a means of controlling hemorrhage has been misused; instead of applying the compression over the bleeding part, it has been carried above the bleeding part and over sound tissue. As a result of this, gangrene in the flaps may occur, with its accompanying septicæmia.

Just before operating the limb should be elevated and held for a few minutes, and at the same time rubbed towards the trunk. The tourniquet should be now placed over the femoral just beneath Poupart's ligament, so as to press against the bone. It should be screwed down quickly upon a bandage placed under the bone and over the artery; if it is slowly turned a large amount of blood will pass into the limb, and the compression is soon sufficient to keep the venous return in the limb, but not enough to prevent arterial blood from entering the limb. Esmarch's bandage is often used instead of Petit's tourniquet, but the

amount of oozing following its use is so great that I prefer digital pressure or the tourniquet, when properly applied. If the Esmarch bandage is used and the main vessels are ligated, irrigation by hot water will control the oozing better than any other means.

Whatever shape may be decided upon, all flaps should consist of skin and connective tissue only, and not muscles. If muscles be included in the flap on the supposition that it will form a soft cushion over the divided end of the bone, the fact that the muscles soon completely atrophies takes away the supposed advantage.

The surgeon stands upon the right side of the limb to be removed, so that he can hold back the flaps with the scalpel, and in doing so he must remember to cut with his scalpel directed at right angles to the long axis of the limb, and the cutting edge slightly turned towards the part of the limb to be removed, and never towards the flap. In this way he cannot button-hole the flap, and the edge of the flap being cut at right angles to the long axis of the limb, will not slough, as it will do if the edge is cut obliquely. The flap should consist of skin and connective tissue and deep fascia down to the muscle; but it is not to include the muscle. The blood-vessels nourishing the flap run between the skin and the deep fascia, and if the edges of the flap be cut at right angles and not obliquely, the extreme edge of the flap is bountifully supplied with vessels. In dissecting up the flaps they should be held by the surgeon's fingers, and never by forceps, which contuse the flaps. The surgeon having dissected up the flaps to a convenient distance and holding the flaps back with his left hand, he is now prepared to make a circular section of the muscles down to the bones, in doing which it is best to allow for a certain amount of contraction of the muscles after they are cut.

When the bone is being sawn through, the limb must be firmly held in a manner to prevent binding of the saw or splintering of the bone.

When two bones are to be sawn through, as the tibia and fibula, the section should be made upon the same level, remembering to saw through the smaller of the two bones first.

The large arteries having been ligated with catgut the blood is allowed to enter the limb, and any bleeding points of size are ligated.

To obtain primary union the wound must be dry, and to stop the oozing the wound should be irrigated with a *bat* bichloride of mercury solution or a number of sponges wrung out of such a solution should be packed into the wound and firmly held for several minutes by the hands of an assistant or by a bandage. Or, if there is much oozing, sutures may be introduced through the flaps, but not tied, and hot sponges packed in the wound. The flaps are then brought over these and moderate pressure applied by a heavy gauze bandage. After five or six hours the wound will be found perfectly dry, and the patient having recovered from the ether and shock will permit the application of a permanent dressing without suffering pain, as it only remains to fasten the sutures previously introduced.

Before the flaps are brought together by the sutures a drainage-tube of *red* rubber—because it contains no sulphur—should be placed in contact with the face of the stump, brought out at each angle of the wound, and cut off flush with the surface of the skin. [Unless this is done the end of the tube may be bent over and completely closed by the dressing.] A good antiseptic dressing is then to be applied.

In three days, if every thing has gone on well, the dressing should be changed under irrigation so as to remove the drainage-tubes, and a new dressing applied. This second dressing can remain unchanged for a week, and then a new and final dressing can be applied. It is thus evident that by this method all the great principles of wound treatment have been observed.—*Four. Am. Med. Ass'n*, May 7, 1887. [G. B. P.]

Lister (Sir Joseph) on Varicocele and its Treatment.—I wish to impress this important fact upon you: do not think, because a man is discovered to have varicocele, that therefore it is your duty to subject him to an operation. The cases which call for operative interference are few, and surgical measures employed under other circumstances are unjustifiable.

If the varicocele causes pain, or by its size interferes with a patient's work, or if it causes mental depression, an operation may be done.

Ablation of the scrotum I cannot commend to you, because the tissue, being elastic, stretches almost immediately after the operation.

Acupressure with pins and subcutane-

ous division of the veins, is a method to be deprecated, as the danger from septicæmia is great, and the operation rarely includes all the varicose veins.

The objection to subcutaneous ligation is, that the spermatic artery is apt to be included in the loop of the ligature as well as nerve filaments and too many of the veins, resulting in insufficient venous return and subsequent atrophy of the testicle.

The best operation, in my opinion, consists in making an incision from three quarters to an inch in length a little below the external abdominal ring, dividing the tissues down to the large venous trunks which are found passing up from the scrotum. These vessels are ligated with a double antiseptic gut-ligature, by which means venous return is cut off by this route. It has been my experience in every instance when operating at this point, to find only "two" venous trunks, whereas the anatomical textbooks gave a number of recurrent vessels.

Recently, however, there has been found to exist a plexus of small veins which communicate with the spermatic vein, and it is upon these secondary vessels that we depend for the carrying on of the circulation in the testicle.—*Medical Register*, April 23, 1887. [G. B. P.]

MISCELLANEOUS.

International Congress on Inebriety.—The Council of the English Society for the Study and Cure of Inebriety, have completed arrangements for an International Medical Congress, to be held at Westminster Hall, London, July 5 and 6, 1887.

The object of this Congress is to present and discuss the problems of inebriety medically, and from a purely *scientific standpoint*, by the best authorities, thus laying the foundation for a broader and more exact study of this subject.

At the close of the second day, a dinner will be served to the Congress by the Society for the Cure of Inebriety; on the third day an excursion and reception will be held at the Dalrymple Home.

Papers and addresses are promised from a large number of the most distinguished physicians.

Norman Kerr, M.D., F.L.S., is President, and T. D. Crothers, M.D., Chairman of the American Committee.

PUBLISHERS' NOTES.

Horsford's Acid Phosphate.—Dr. W. W. Gardner, Springfield, Mass., says: "It seems almost tautological to recommend Horsford's Acid Phosphate as a valuable local and stomach tonic. I have made use of it in my family and in practice for years. I will, however, repeat what my practice confirms, that I value it, when taken according to directions, as an excellent preventive of indigestion, and a pleasant acidulated drink when properly diluted with water and sweetened."

Pinus Canadensis—Gonorrhea and Granular Ulcerations.—I have used Kennedy's Pinus Canadensis in gonorrhea most successfully. I am now treating cases of chronic cervical endometritis, with granular ulcerations, and think it particularly indicated there. It was in such practice, I believe, which elicited Sims' encomiums of its merits. T. N. CLARK, M.D.
Regan, Texas.

Iron Alum Mass.—I believe the "Seven Springs Iron Alum Mass" to be the best remedy we have for diseases peculiar to females and uterine complaints.
GEO. M. D. PATTERSON, M.D.
Englewood, Texas.

Lactopeptine.—I have been using Lactopeptine this summer with surprisingly good results; have now a babe who takes five grains just before nursing each time during the day. The milk, which cannot be retained at all without taking the medicine, is perfectly digested, and although emaciated when beginning the treatment, is now fat and healthy.

Toledo, Ohio. W. C. CHAPMAN, M.D.

Lactated Food.—Lactated Food is the very thing. It is undoubtedly the best food in the market for children suffering from wasting atrophy. I have tried various preparations in those cases and find Lactated Food "par excellence." If physicians will use more of it the infant mortality will be largely reduced. J. W. RITCHIE, M.D.
Stephenville, Texas.

BALTIMORE, Jan. 20, 1875.

Colden's Liquid Beef Tonic.—I certify that I have used "Colden's Liquid Beef Tonic" largely in debility, febrile and nervous diseases, and that I have found it one of the most reliable of our nutrient tonics now in use or to be found in pharmacy.

JOHN J. CALDWELL, M.D.
71 N. Charles St.

Milk of Magnesia.—One of the simplest and best articles ever used for correcting the different irregularities of children which are so prevalent during the summer months is "Phillips' Milk of Magnesia." See advertisement on cover page.

Crystalline Phosphate.—Yours and sample of "Crystalline Phosphate" to hand. I am pleased with its appearance; its compact form must commend itself to every physician. Shall be pleased to use it where indicated, and continue it if equal to other phosphates, as it certainly is handier and cleaner. C. F. WAHRER, M.D.

Mt. Hamill, Iowa, April 4, 1887.

Murdock's Liquid Food.—This food is used without a doubt by more physicians in this country and Europe, than any other pharmaceutical preparation ever put on the market. See advertisement on cover page.

Cherry Malt Phosphites.—If you pay express charges, you can obtain a bottle of this well-known phosphites by sending to the Liebig Pharmacial Co., 74 Maiden Lane, New York.

For Feeble-Minded Youth.—Send to the Superintendent of this well-known asylum for full particulars, Dr. Geo. Brown, Barre, Mass.

Abdominal and Uterine Supporter.—All our readers should have a catalogue of the supporters made by Flavell & Bro., of Philadelphia, Pa. See advertisement.

The Gurney Cottage.—If you should have any patient suffering from nervous affections, write to the superintendent of the above sanitarium, and receive information as to rates, etc. It is situated at Atlantic City, N. J., and cannot be equalled as a summer or winter resort.

Medical and Surgical Sanitarium.—This Sanitarium has gained a reputation second to none, for its being in one of the healthiest locations in the United States. It has perfect sewerage, something not to be found at the majority of the so-called Sanitariums of the present day, and it would pay any physician to be acquainted with it. Send for catalogue to the superintendent.

Cod-Liver Oil Tonic.—In prescribing cod-liver oil, if you order Scott's Emulsion you will give your patient not only a pure oil but a combination holding the hypophosphites of lime and soda in intimate mixture.

THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

VOL. IV., No. 7.

July, 1887.

WHOLE No. 43.

LEADING ARTICLES.

On the Treatment of Malignant Pustule (Anthrax).—On January 27, 1887, there was a serious outbreak of anthrax on a farm in England, forty-nine cows dying and eighteen being killed within twenty-four hours.

Some of the carcasses were sold before the authorities made a post-mortem and microscopic examination.

Two brothers dressed some of these carcasses, and ten days later one of them consulted a surgeon for a pimple on his right forearm which caused some anxiety.

At the end of twenty-four hours there was a dark brown eschar surrounded by a ring of vesicles, around which was a livid red area and extensive brawny œdema extending over two thirds of the right forearm; no swelling of the axillary glands could be detected, and he did not complain of any pain in any other part.

The pustule was then freely excised down to the fascia of the muscles and the wound cauterized with pure carbolic acid and dressed with carbolized oil. The patient made a good recovery.

The other brother, four days after the visit of the first, presented himself with a similar lesion on the left forearm, and was similarly treated, with recovery.

These cases help to show the period of incubation of malignant pustule; both men were exposed to the inoculation at the end of January 27th and the beginning of January 28th, and in one case it was first noticed on February 6th, and in the other on February 7th, giving a period of incubation of between ten and eleven days.

They also go to prove that where cases of malignant pustule are operated upon in time, that is, before the bacilli have got into the general system, the patient has a very good chance of recovery, and, as in

these cases, without the slightest return of the poison or any detriment to the constitution.¹

In the *Lancet* of February 19th Mr. Bryant reports two of a series of seven cases of malignant pustule successfully treated by excision and in some cases the application of caustics.

The same journal, in the issue of April 23d, contains the report of a case of anthrax which occurred in a tanner who was in perfect health, with no evidences in his urine of Bright's disease or diabetes.

Three days before being seen by his physician a "boil" appeared on the back of his neck. The pain from this confined him to the house, but not to his bed, until the morning of the day he was visited, at which time he fainted, but recovered and went to bed. Afterward he became insensible and was in that condition with convulsions when seen.

The pustule was excised but the patient died in five hours in coma.

Mr. Dunn, in the *Lancet* of April 30th, says: "There were at least two cases of coma amongst the fatal cases of malignant pustule at Guy's, in the year 1884, during the latter part of which I was acting as surgical registrar, in which death was preceded by convulsions and coma. The necropsy in these cases revealed extensive hemorrhage over the cortex of the cerebrum beneath the arachnoid. Of course, in addition to this, there were other lesions discovered characteristic of death from malignant pustule. I do not think we ought to be surprised when we meet with subarachnoid hemorrhage in these cases, considering how frequently we meet with extravasations of blood under other serous surfaces, as the pleura, etc.; in fact, I should be inclined to look upon meningeal hemorrhage, like

¹ *Brit. Med. Jour.*, March 19, 1887.

œdema of the glottis, as not a very unfrequent complication which may directly induce a fatal termination in a case of malignant pustule."

Although early excision of the pustule gives such good results in the treatment of this affection, other means are at hand.

The *Paris Médical* of January 29th publishes notes of three cases of malignant pustule, described by Dr. D. Frederico Rivas, which were cured with a paste composed of quinine powder and essential oil of turpentine. The first case was that of a woman suffering from a pustule on the metatarso-phalangeal joint. Various methods of treatment were tried without success. On the application of the quinine and turpentine paste the pain immediately ceased and the œdema disappeared; a scab alone remained, which came away on the fourth day. The paste was equally successful in the case of a shepherd who had been stung by a fly in the lower portion of the temporal region; intense œdema of the head and neck ensued. A third case of malignant pustule was cured by the same treatment. The powder and essence should be employed in sufficient quantities to form a soft paste, which should be often renewed, as it dries rapidly.¹

In the *London Medical Record*, December 15, 1886, there are reported cures of anthrax by the injection of a two per cent. solution of carbolic acid about the pustule at varying intervals of time; also by painting the swelling with pure carbolic and giving large doses of quinine; by cauterization with the red-hot iron, and quinine internally. [G. B. P.]

Bouchard on the Treatment of Typhoid-Fever.—The diagnosis being assured he prescribes a purge, one half an ounce of sulphate of magnesia, which is to be methodically repeated every three days. Secondly, he gives one third of a grain of calomel every hour for four consecutive days. Thirdly, he obtains intestinal antiseptis by means of a mixture composed as follows: Powdered vegetable charcoal, 100 parts; iodoform, 1 part; naphthaline, 5 parts; glycerine, 200 parts; and peptone, 50 parts. This forms a black semi-liquid magma, and a teaspoonful is given in a third of a glass of water every two hours. Morning and night the lower bowel is

washed out by an injection of a pint of 1-1,000 carbolic solution.

From first to last the patient is bathed eight times a day. He preserves quinine for cases where the temperature, in spite of the baths, remains elevated. A rectal temperature of 104° in the morning and 105° in the evening he considers an indication for the use of quinine.

He gives 30 grains during the first two weeks, 25 grains the third, and 15 grains during the fourth and fifth weeks, as follows: He gives it in about eight-grain doses every half hour until the above-mentioned amounts have been taken. He advises that seventy-two hours intervene between these administrations of quinine.

The diet he employs consists of beef tea, made with barley, and given freely, glycerine (in combination mentioned above), and lemonade with the addition of a little wine.

The bath into which he puts his patients is always two degrees (C.) lower than that of the patient at the time; he then cools it down at the rate of a tenth of a degree in a minute, never going below 86° F.

The results of this treatment in the first 129 cases was a mortality of 7%. The mortality of the first 266 cases, however, rose to 11.7%, the mortality at the same hospital previously having been 18%.—*Nice Medical*, April, 1887.

Operations for Phimosis in the Treatment of Various Nervous Affections.—Magruder's cases are epitomized as follows:

Case 1.—Retention of urine from birth, necessitating use of catheter. Circumcised on fifth day; permanent relief. Case 2.—Age, two. Backward in walking; talipes valgus both feet. Preputial adhesions broken down. Faradism to legs. Perfect recovery. Case 3.—Age, two. Unable to walk. Preputial adhesions broken down. Recovery. Case 4.—Age, four. Nocturnal incontinence. Circumcised. Cured. Case 5.—Age, eleven. Pain and impaired mobility in left hip. Circumcision. Cured. Case 6.—Age ten. Painful urination. Preputial adhesions ruptured. Cured. Case 7.—Age, eighteen months. Incontinence. Circumcision. Cure. Case 8.—Age, eight. Continual incontinence. Circumcision and strychnia. Ultimate recovery. Case 9.—Age, ten. Pain and weakness in legs; head-

¹ From *Brit. Med. Jour.*, March 19, 1887.

² *Jour. Am. Med. Ass'n*, April 9, 1887.

ache and palpitation. Preputial adhesions broken down. Cure. Case 10.—Age, nineteen months. Unable to walk. Standing difficult; head thrown back; peevish; restless; bow-legged; whined continually. Preputial adhesions broken down. Cure. Case 11.—Age, two. Weak legs. Difficult locomotion. Circumcised. Improved. Case 12.—Age, three. Walked poorly. Incontinence. Preputial adhesions broken down. Incontinence cured. Walk improved. Case 13.—Age, six. Backward in walking. Incontinence. Removal preputial adhesions. Cured. Case 14.—Age, two and a half. Unable to stand. Circumcision. Malt and hypophosphites. Cure. Case 15.—Age, two. Weakness of legs, which are dragged. Circumcision. Improvement. Case 16.—Age, two. Awkward and stumbles. Slight talipes valgus. Circumcision with improvement. Case 17.—Age, two. Unable to stand. Circumcised with rapid improvement. Case 18.—Age, one. Hemiplegia and convulsions. Circumcision and rapid improvement. Case 19.—Age, eleven. Incontinence of urine. Adhesions broken. No improvement. Case 20.—Age, four. Incontinence of urine. Circumcision and cure. Case 21.—Age thirteen. Very frequent convulsive seizures. Almost complete cessation by circumcision. Complete relief (?) from bromides. Case 22.—Age, six weeks. Never a good night's rest. Cried incessantly. Legs in constant motion. Case 23.—Age, ten weeks. No rest at night. Continually crying and fretting. Dribbling of urine. Opisthotonos. Circumcision. Cure. Case 24.—Weakness in legs. Dizziness. Pain in lumbar region. Nocturnal incontinence. Preputial adhesions broken down. Cure.

Adams says¹: "In only one instance have I known the enuresis to continue after circumcision. The boy, eleven years old, retained his urine all right for several days, when the enuresis returned, but not as bad as before. As I had treated him for gonorrhœa—as well as a sister of nine years, whom he had infected—six months before operating, and knowing him to be incorrigible and untidy, I rather incline to the opinion of his parents that he now wets his bed from force of habit and laziness. It may be due to stricture, but if he hears that I am in his neighborhood he runs away, so it has been impossible to exclude this cause.

"The prejudice which formerly existed among the laity against circumcision seems to be rapidly passing away, and now, when we can offer a reasonable hope that the operation will cure the disease, there is an eagerness on the part of the parent, and, many times, the child, to have it done.

"One objection to the operation is that the glans will be left uncovered, and that it destroys to some extent the sensitiveness of the organ. If this were true, it would in many cases prove a great blessing, but, unfortunately, it is not true. Another objection is that the beauty of the organ is destroyed, whereas, in fact, if the circumcision is neatly done, the penis presents a far better appearance than it does with a redundant foreskin.

"From the foregoing it will be evident that I am in favor of operating early, if the prepuce covers the glans, whether retractable or not, and not regarding the operation as a *dernier ressort*."

Sinkler reports² a case of epilepsy apparently due to genital irritation, and cured by circumcision.

"Irritation of the prepuce or of the glans penis, even when not associated with masturbation, is believed by many to be the source of divers reflex nervous disorders, including epileptic convulsions, and many operations of circumcision have been done to relieve these conditions, with varying success.

"To add some testimony to the subject, I wish to report the following case of marked epileptic fits associated with irritability of the genitals, and in which the attacks ceased after the operation of circumcision.

"Frank P., colored, æt. three years and five months, came to my clinic at the Infirmary for Nervous Diseases July 19, 1886. His parents are healthy, and have five other children; none of these have had fits, but one has had chorea. He was well until December, 1884, when he had two spasms. These were attributed to teething and taking cold. In January, 1885, he had another fit. The attack was well marked, and lasted three or four minutes. Since that time he has averaged one fit a week. The attacks are severe, the convulsive movements being general, and afterwards he is dull and sleepy. For several days past he has had an attack every day.

"The child is well nourished, and shows

¹ *Arch. of Pediatrics*, April, 1887.

² *Med. Times*, Feb. 19, 1887.

no sign of rickets except that he is backward in teething. He is intelligent, and talks freely. The prepuce is elongated and inflamed at the edges, but can be retracted over the glans. Any touch, however, brings on an erection of the penis. The mother says that he handles the penis frequently, and seems to have some discomfort about it.

"He was ordered potassium bromide, gr. ii. ter in die. In one week returned and reported having had one attack. The bromide was increased to gr. v., given as before.

"August 2d.—The boy has had thirty-five or forty attacks during the past weeks; some days twelve or fifteen fits. He has become unable to speak, and seems to have lost his intelligence. The genitals are very irritable; a touch of the penis makes it rigid. Circumcision was advised, and the operation was performed by Dr. H. E. Goodman on August 9th. The bromide was continued in five-grain doses three times a day.

"In the week after the operation was done he had two attacks. Since then there have been none. The bromide was taken for about three weeks.

"I examined the child on December 27th, and he seemed well. He was bright and active, and talked freely.

"Gowers speaks of a case of epilepsy in a boy of thirteen years, who had twelve or fourteen attacks a day under various treatment. It was found that he was addicted to self-abuse, and a blister on the prepuce reduced the fits to from two to seven a day. Circumcision was then performed, and the attacks ceased at once and did not recur. This author advises circumcision in all cases of epilepsy, when masturbation is suspected."

Ayres reports¹ a case of acute melancholia apparently cured by circumcision.

The patient was thirty-eight, single, a cooper, and mute since two and a half years of age from scarlatina. He was of good physique, had always enjoyed average health, and was industrious in his work. Habits temperate excepting the immoderate use of tobacco, and occasional over-indulgence in beer.

The present mental disorder had existed a little more than a month, though his general health had not been good for a

year or more. He had lost flesh, and was irascible. The mental symptoms were as follows: He discontinued work, remained in-doors, and declared he would die. He became exceedingly timid, was apprehensive, and fancied he would be arrested and hung if he left the house. He was morbidly suspicious. His appetite was capricious, bowels irregular, and sleep much disturbed.

He was the picture of despair, with sad, appealing expression, eyes dark, pupils sluggish, tongue anæmic and stained with tobacco. Hepatic dulness normal. First sound of heart slightly roughened. Lungs and spleen normal. Patella reflex markedly exaggerated. Decided spinal tenderness on pressure. Pulse and temperature normal. Prepuce contracted, but not adherent to glans, and retracted with difficulty, exposing a small bluish-white glans, while the frenum and lips of meatus were puffy and red. A sound, No. 23 French scale, being passed, revealed an exquisitely sensitive urethra. There was no history of *specific* infection, nor indications of onanism.

The redundant prepuce was removed and the wound united in a few days with little suppuration. At the same time the patient improved conspicuously. His family observed in him a more natural demeanor and expression. He rapidly gained flesh and slept well. None of the old delusions were referred to excepting on one or two occasions. He was persuaded to go out for a walk the first time for several weeks, and then was eager to be out much of the time. The patella reflex sensibly diminished, though the irritation of the urethra continued. For the relief of this the cold sound anointed with cocaine ointment was passed every two or three days and retained *in situ* for ten minutes. At this date, five weeks after the first visit, he is apparently free from all delusions and entirely rational. He has gained at least fifteen pounds in weight. His appetite is excellent and his sleep sound. He spends much time out in the air and is anxious to resume work.

On Rags as a Means of Carrying Infection.—In the April number of the *Sanitarian* is published the report of the committee of the American Public Health Association on the disinfection of rags, and in this report is collected a large amount of evidence to show that diseases may be propagated by rags or infected clothing.

¹ *Pittsburgh Med. Rev.*, June, 1887.

The following is a summary of some of the cases collected by the committee :

1. A rag-picker from Amsterdam introduced cholera into the city of Tilburg.

2. At Dresden a rag-picker was the first victim in that commune.

3. At Mearsen the first one attacked with cholera was a rag-picker.

4. At Wormerveer, in 1886, rags communicated typhus-fever to various people.

5. In the canton of Solothern, 17 workmen, of whom 11 died, were seized with cholera, who were engaged among rags in the paper-mills. There was no cholera within the canton, and the rags came from a cholera district.

6. A sailor died of cholera in Europe; his clothing sent to Maine (U. S.) communicated the disease.

7. Cholera was introduced at Carthage, O., Crow Run, Minn., and Yankton, Dak., by the baggage of immigrants.

8. Nine cases of cholera, four of which were fatal, occurred at Mühlhausen (Thuringia) in 1873, was introduced by clothing brought by a woman from St. Louis, in the United States, *via* Hamburg and Bremen. Rags in bale have much better condition for preserving contagion than baggage.

There are also numerous cases reported in which small-pox originated in paper-mills, and there is no doubt of the possibility of the conveyance of small-pox infection by both foreign and domestic rags, but Dr. Withington¹ states that there is no case in which cholera was shown to have been transmitted by foreign baled rags, though there are undoubted evidences of its having been transmitted by means of clothing.

In the *British Medical Journal* for February 12, 1887, is an account of the report of a committee to the Medical Society of Riga concerning an epidemic of what is known as rag-sorters' disease, which broke out among the female rag-sorters in a paper factory at Ligat.

On April 25th, one of them was attacked; on the 28th, seven succumbed to the disorder. The first symptoms were tremors, high temperature, and general *malaise*. There was loss of appetite, headache, dyspnoea, weak pulse, and cough accompanied by moderate expectoration. When the disorder proved fatal, the tem-

perature fell, the pulse became weaker, and cyanosis and collapse ensued. *Post-mortem* examination showed rapid decomposition of the tissues, with mediastinal, pleural, and pericardial effusion, and enlargement of the bronchial glands and the spleen. M. Krannhals studied these lesions from a histological point of view, and discovered microbes of three different kinds in the blood—some like the bacilli described by Koch as occurring in oedema, some arranged in rows, and others having the appearance of cocci. The microbes were most numerous in the parenchyma of the lungs, in the bronchial tubes, and in the cellular tissue of the mediastinum. The fluid of the pleural effusion injected under a dog's skin caused malignant oedema and death in three days. Cultivation of these products in Agar-Agar proved the identity of these micro-organisms with the microbes of malignant oedema as described by Koch and Hesse. M. Krannhals therefore considers that the epidemic described is analogous with malignant oedema. [G. B. P.]

Hæmic Changes in Malignant Disease.—Hayem² has estimated that the number of leucocytes in a cubic millimetre of normal blood is about 6,000, but that they vary more in health than do the red corpuscles. He has estimated them in various kinds of neoplasm with the result of finding that in all such cases their number is augmented.

He has examined schirrus of the breast, 14 cases; epithelioma of the breast, 2; schirrus of the pancreas, 2; epithelioma of the testicle, 1; osteo-sarcoma, 7; lympho-sarcoma, 3; and many cases of epithelioma of the uterus, and cancer of the stomach. The average of the white corpuscles in these different cases of malignant growth was as follows :

In the cases of uterine epithelioma the number was 7,800 per cub. millim. ; in the schirrus of the pancreas, 9,500 ; in cancers of the breast, 11,350 ; in epithelioma of the testicle, 12,350 ; in osteo-sarcoma, 19,500 (in a case of sarcoma of rapid growth and small cells, 52,700) ; in lympho-sarcomata, 11,000–20,000.

In all these instances there exists at the same time generally a diminution of the red corpuscles. The author points out the diagnostic utility of these facts by citing a case in which he thus decided upon the

¹ Editorial, Boston *Med. and Surg. Jour.*, April 21, 1887.

² *La Tribune Médicale*, May 15, 1887.

malignant nature of a neoplasm of the foot.

McArdle, in a recent paper on sarcoma, detailed cases which showed the deterioration of the different tissues of the body apparently as a result of the disease. He noticed in all his cases a great diminution of the red corpuscles of the blood, and a slow and incomplete coagulation of that fluid. In these cases he met with spontaneous fractures, and on examining the bones he found them brittle, and the red marrow in a state of fatty degeneration. In seeking an explanation of the decrease of red corpuscles in the blood, he concluded that the destruction of the red marrow of the bones led to a diminution of their manufacture. He explained the emaciation of the patient by the lessened oxygenating power of the blood, which, in some of the cases, looked like serum, so poor was it in corpuscles.

Perhaps upon this deterioration of the blood depends the reputed efficacy of lime in the treatment of malignant disease. Hood first called attention to this treatment nearly twenty years ago, and recently¹ urges upon those who possess the necessary facilities that a more extended trial should be given to this agent than it appears yet to have received. His own opportunities of employing it in suitable cases have not been large, but the results which he has witnessed have been sufficiently remarkable to justify him in seeking for them a more extended publicity.

In the paper referred to he related in detail the case of a lady nearly eighty years of age who was the subject of schirrus of the breast, and in whom the growth sloughed away and left a healthy surface after a course of carbonate of lime, administered in accordance with a recipe which was current in her family. She manufactured her carbonate of lime by baking oyster-shells in an oven and then scraping off the calcined white lining of the concave shell. The substance thus obtained was reduced to powder, and as much as would lie on a shilling was taken once or twice a day in a little warm water or tea. It was said that perseverance for at least three months was necessary before any good result was to be expected. The powder was probably almost pure carbonate of lime, but it might possibly contain a small admixture of odine.

Wells has used lime largely in the treatment of uterine fibroids and other tumors, and was convinced that processes of atrophy and calcification resembling spontaneous change or degeneration sometimes occurred in these cases.

Stradling reports² a confirmatory case, where the opposite breast became involved with a growth, having every appearance of malignancy, several months after the fellow gland had been removed for a malignant tumor. Treatment by Hood's method seemed to entirely check the morbid process, since a year later the growth had not only not increased, but presented a much healthier appearance, and the element of pain, which had been extremely annoying, had left altogether. He did not use oyster-shell, but the following imitation of it: He supplied her with a quantity of dried carbonate of lime, adding thereto $2\frac{1}{2}$ per cent. of the phosphate, to imitate the product of the shells as nearly as possible. The true proportion should have been about 1 per cent. Of this she was to take as much as would lie heaped upon a sixpence three times daily, in a dessertspoonful of milk; stirred up in a larger quantity of fluid, a great part of the powder settles before it can reach the lips, and is apt to be overlooked at the bottom of the cup, while a dessertspoonful is introduced bodily into the mouth, and the milk hides the disagreeable appearance of the lime.

Tumors of the Pituitary Body.—

Leclerc³ narrates the history of a man of sixty-four, not syphilitic or alcoholic, who, seven years before admission, after a dizzy spell, had an attack of loss of consciousness, followed by no spasm or paralysis nor disturbance of speech. In June, 1885, there came on a violent pain occupying the right side of the head and the right eye. A year later rapid failure of vision in the right eye came on and a ptosis of the right lid. Later the same sequence of symptoms developed on the left side. Cerebral vomiting had existed for months.

On admission to the hospital there was double exophthalmus, double ptosis, more marked on the right side, slight dilatation of the right pupil with almost no reflex in either pupil. Amaurosis on right side much impaired, vision on the left side, and optic nerve atrophy on both sides. There was

¹ *Lancet*, May 28, 1887.

² *Ibid.*

³ *Lyon Médical*, April 24, 1887.

no motor disturbance except a deviation of the tongue to the right. General sensibility was normal excepting the headache. There was towards the last anosmia and dementia. Death from marasmus was preceded by wild delirium. An autopsy disclosed a tumor the size of a turkey's egg occupying the site of the pituitary body.

An obscure case with a similar lesion is reported by Miles,¹ who was called to see a lady who was lying in a semi-comatose condition, in which she had lain for three weeks. She was fifty years old, well-nourished, looked normal, could be aroused, but took no notice of those about her, would get up to attend to the calls of nature, or eat when aroused. There was no emaciation, and she gave the idea of hysteria except that she was too old. The family did not seem anxious about her. A week later he found she was dying, much emaciated, comatose, passing her evacuations in bed. He made a post-mortem examination. There was not much emaciation about the body. No escape of blood, and the tissues were very dry. The skull was not thick, dura mater not inflamed, no enlarged pacchionian glands. He found the watery look of the pia mater so often observed after congestion. The pia stripped off very easily. The brain seemed to be normal. He could find nothing but some congestion in the corpus striatum, and was about to put the brain back when he noticed a trickling of blood by the sella turcica. He felt around the pituitary gland, which he had not removed, and found a black mass which ran down to the jugular foramen, a little fibrous melanotic deposit, but there was nothing further. There was evidently a melanotic degeneration of the pituitary gland. There had been no hemiplegia, no paralysis, no congestion of the head and face.

THERAPEUTICS.

Barnsfather (J.) on Euphorbia Herterodoxa.—In a letter printed in the *N. Y. Med. Jour.*, June 4, 1887, the author says: "I have at present a patient in Cincinnati who is suffering with carcinoma uteri, and who was at death's door from five weeks' hemorrhage previous to my taking charge of the case. I have had her

under the alveloz-milk treatment for fourteen days, and in that time the improvement has been marked. The physiological action of the drug is as follows: On application to the os, there is an intense burning feeling in the vagina, lasting from two to four hours. Absorption of the medicine evidently takes place, as in six hours after every application profuse discharges from the kidneys of a highly colored and offensively smelling urine commence to flow, and continue at intervals of two or three hours, until about a gallon has passed. The local bleeding ceased after three applications to the os, and since that time there has been a continuous flow of pus. I may state also that the lancinating pains have completely ceased, and she was able yesterday to get out of bed, dress herself, and walk into another room, without any ill effect whatever. She also eats and sleeps well since the application of the remedy, with the exception of getting up to pass water every two hours during the night. *The skin also lost its sallow hue*, and the patient states that her nervous irritability is entirely gone. I apply the drug to the os uteri with a brush, through a glass speculum, and repeat the application every twenty-four hours. Eleven small pieces from the inside of the cervix have passed, and I can push my finger easily to the os internum. Manipulation causes no bleeding now."

In view of the unreliability of the milk, the author generally prefers to use the resin, which is made by treating the alveloz with water and later with absolute alcohol.

He tampons the vagina in all cases. He prepares his tampons by saturating them with benzoic acid dissolved in alcohol. He uses them dry, and packs them against the cancerous mass, and they act as a disinfectant to the discharges as they are absorbed. After all the cervical cancerous growths have been removed, he saturates the tampons with resorcin dissolved in glycerin (one to seven), and applies after the alveloz has been placed in the uterus. It seems to act very nicely, causing the stump to heal over.

Two Methods of Making a Compatible Iron and Salicylic Mixture.—Dr. Peabody,² of New York, uses the following formula:

¹ *Maryland Med. Jour.*, May 28, 1887.

² *Med. News*, Dec. 11, 1886.

℞ Acidi salicylici	gr. xx.
Ferri pyrophosphatis	gr. v.
Sodii phosphatis	gr. j.
Aquæ	℥ ss.

This method of giving this drug in rheumatism has now been fairly tested. It may be said to agree as well with the stomach as any other, and it has the great advantage of not been followed, even if its use be long continued, by the severe anæmia that so often follows the use of salicylic acid, if it be given without iron.

The dose which is described in this formula is given every two hours until improvement justifies a diminution in the frequency, or until constitutional effects are pronounced.

Dr. S. Solis-Cohen,¹ of Philadelphia, uses the following combination :

℞ Sodii salicylatis	℥ iv.
Glycerini	f ℥ ij.
Ol. gaultheriæ	℥ xx.
Tr. ferri chloridi	f ℥ iv.
Acidi citrici	gr. x.
Liq. ammonii citrat. (B. P.),	
q. s.	f ℥ iv. ℥

The mixture is clear, and is not unpalatable. The usual dose is two fluid drachms in water, three or four times a day. The quantities and proportions of the active ingredients may of course be varied according to the intended frequency of dosage, and other circumstances. In cases which are rather subacute than chronic, it is sometimes given every second hour, until the physiological effects of the salicylate are produced, and then at longer intervals.

Allen (C. W.) on Naphthol.—The scaly varieties of eczema were found to be those most benefited. In the moist forms the irritation produced by naphthol was too great, unless used in a mild form, as in a starch-paste in strength of from five to fifteen grains to the ounce. Eczema of the scalp was almost always greatly benefited, and several cases were quickly cured. Internal treatment was usually employed at the same time.

Old chronic, indolent, and foul ulcers were stimulated by naphthol and usually improved.

In scabies it proved curative in a short time.

In impetigo and impetiginous eczema naphthol ointment gave great satisfaction, and speedily caused a disappearance of the lesions.

In general idiopathic pruritus, pruritus hiemalis, pruritus senilis, and pruritus ani, it invariably acted well, giving quick relief and proving often speedily curative.

Dandruff of the scalp, whether associated or not with alopecia, has been without exception cured.

Alopecia, when due to this condition, has in all cases been improved, and in seven of the patients, who were ladies, has been practically cured.

In pediculosis results were always highly satisfactory, the eczema and other changes due to irritation quickly subsiding under the treatment.

In furunculosis he used a drachm or half a drachm of naphthol to an ounce of lard or vaseline and avoided poultices.

One case of carbuncle upon the neck was likewise treated in this manner, and healed quickly and well without lancing.

Seven cases of psoriasis are recorded. One, of the scalp, was cured in a short time. Two now under treatment, in which the collodion is being applied, are doing very well. The patches lose their scales and disappear as quickly as they often do under chrysarbin, without the danger of inflammation of the surrounding skin and the disagreeable feature of staining both skin and clothing.

In dermatitis the results have been favorable, but strong applications must not be used.

In trichophytosis of the scalp in children he has been pleased with the use of naphthol. In adults where the lesions are upon the skin, and in trichophytosis barbæ, he does not speak so favorably.

In two cases of papular eczema closely resembling Hebra's prurigo, it acted as a charm.

In favus, of which there were four cases, its benefit consisted in a removal of the sickening odor and in keeping the heads in good condition in the intervals of more energetic treatment.

In eczema marginatum and in urticaria it appeared to be a valuable application. In the other affections on the list it cannot be said to have any advantage over hundreds of other local dressings.

Whenever antiseptics are desired, and bacteria or germs are to be destroyed, naphthol has an important rôle to play ; it is a valuable detergent and deodorant. In almost all diseases of the scalp it appears to exert an influence for good.

¹ *Med. and Surg. Reporter*, May 28, 1887.

Under the author's personal observation it never has exerted any deleterious effects, but three patients with scabies in the Charity Hospital were thoroughly rubbed at the same time with an ointment of naphthol applied to the whole surface of the body. Some hours later they were all seized with symptoms closely resembling those of intoxication from alcohol—singing, shouting, and acting in a dazed and disorderly manner.

Where a penetrating effect is desired, the author uses a salve made in the following proportion :

R	Naphthol (beta)		5 parts.
	Adipis		10 "
	Lanolin		85 "

M.

The following paste has given greater satisfaction than the salve :

R	Naphthol (beta)		gr. v. to xxx.
	Pulv. amyli		3 iij.
	Adipis		3 j.

M.—Ft. pastam. SIG.—Apply quickly.

To this oxide of zinc may be added at times with benefit.

He had a naphthol collodion prepared, and has employed it quite extensively. It acts well in psoriasis, ulcers, trichophytosis, etc.

Mixed with starch powder, talcum, Fuller's earth, or mineral earth, it has given excellent results in moist syphilitic lesions about the anus and scrotum, also in intertrigo, venereal warts, and ulcerations.—*N. Y. Med. Record*, May 21, 1887.

Williams (G. A.) on Sulphuretted Hydrogen Inhalations.—The doctor writes to the *Medical News* as follows: My attention having been attracted by an article entitled "Sulphuretted Hydrogen Inhalations," in your issue of May 7, 1887, in which are described the methods employed at Allevard, France, I respectfully desire to call your attention to the fact that these identical methods have been in operation in Sharon Springs, N. Y., since June, 1884, and are described in Dr. Beverley Robinson's "Nasal Catarrh and Allied Diseases" (second edition, p. 141).

During the past three years I have had occasion to use them in my own practice, in many cases of diseases of the respiratory organs, and with gratifying success. As the use of sulphuretted hydrogen is now receiving marked attention from the profession, it seems to me eminently proper

that medical journals, while directing special notice to results obtained in foreign lands, should not ignore the employment of the same means in our country, and within easy access of those of their readers who may not be able conveniently to cross the sea.—*Med. News*, May 14, 1887.

Rohmer on Artificial Maturation of Cataract.—A free discision of the lens is first made with a needle; next the anterior chamber is tapped and all the aqueous humor evacuated; then massage over the cornea through the upper lid is practised for a short time (few seconds). In from twenty-four to thirty-six hours the opacity is nearly complete, and it is total on the third or fourth day. After waiting a few days longer extraction is accomplished. Evacuation of the cortical masses must be complete, and this is much aided by an irrigation of the anterior chamber.—*La France Méd.*, May 14, 1887.

Hare (H. A.) on the Influence of Beer on Salivary and Gastric Digestion.—The beers examined varied in their action as much as fifty-nine minutes, and while most beers do not retard digestion in all probability in the stomach, others aid digestion very materially. Thus, in one case it was noted that even in the test-tube the average delay in gastric digestion equalled but one minute and thirty seconds.

While we can use beer as a tonic and stimulant to digestion, we cannot regard it as a beverage possessing any real nutritive value, since its chief nourishing constituent is glucose, which is, however, in very small amount, the greater part of it having been transformed in the fermentation into alcohol and carbonic acid.—*Med. News*, June 11, 1887.

Gadd (S. W.) on Rectal Alimentation by Suppositories.—Whilst the lower bowel—of which the rectum is a part—cannot perform the function of the stomach, namely, that of digestion, it can and does very well perform the functions of the small bowel, namely, assimilation or absorption, when called upon to do so.

Hence, if we administer to the lower bowel such foods as have been already digested, it can very readily appropriate the same to the blood.

Of course the amount of nourishment taken into the system is relatively small, but every physician knows what a small quantity at times, when the patient's life

hangs by a slender thread, is sufficient to tide him over the moment of wrestling for life, until his own strength begins to return and the normal functions again show their presence.

The use of nutrient suppositories has been suggested, but I believe they have not yet been brought to practical use. The consideration of this caused me to carry on some experiments with a view to the best manner of producing them.

For this purpose I proceeded to prepare a pancreatized extract of beef in the following manner:

I made use of liquor pancreaticus as representing pancreatine, made by digesting the fresh pancreas in four times its weight of diluted alcohol. Of course the extract of pancreatine may be used with same results.

To sixteen ounces avoirdupois of finely minced beef, off the rump, add one pint of water and two fluidounces of liquor pancreaticus and one drachm of sodium carbonate.

The mixture should be kept at a temperature of about 120° to 140° F., with occasional stirring from four to six hours, adding water from time to time as it becomes lost by evaporation. Then throw the whole upon a linen or muslin strainer, and express with gentle pressure. Neutralize the filtrate with hydrochloric acid in a porcelain dish, and, with a moderate degree of heat, evaporate down to the consistence of an extract, or, better, to dryness, if it can be accomplished without a high degree of heat. A much better preparation I think could be obtained by evaporating *in vacuo*. This extract of meat will keep well in a closed vessel, and represents thoroughly, if made with care, the nutritive value of the meat.

Various substances have been used as a base for suppositories, but in my hands, after various experiments, the superiority rests with the mixture of gelatin and glycerin, which, for convenience, we will call *glycogelatin*.

Glycogelatin is made by taking one ounce avoirdupois of pure gelatin; cause it to become soft by soaking in one fluidounce of water until the whole of the water has become absorbed. Dissolve this in three and a half fluidounces of glycerin by means of a waterbath, and allow the mass to cool and solidify.

When nutrient suppositories are desired they may be prescribed for thus:

℞ Extract carnis pancreatici, gr. c;
Olei theobromæ, vel
Glycogelatinæ, q.s.
Ft. suppositor. x.

—*Therap. Gaz.*, May 16, 1887.

Todd (J. S.) on Quinine in Infantile Colic.—There is a disease of infants, known among old women as *three-months colic*, which really and truly does exist, but in my reading not in the text-books, or if so it appears under another name. The age at which it develops is generally about the second week after birth. During the day the infant sleeps soundly, but as night approaches the little stranger begins to exercise his lungs, which practice he continues for from two to eight hours. Paregoric, Dewee's carminative, and calomel alleviate, palliate somewhat the suffering. The bowels are hard, the legs drawn up, rumblings are heard over the abdomen, and frequently an escape of gas is followed by complete relief of pain. We flatter ourselves that the key to the disease has been found, and address ourselves with renewed energy to the digestion, using largely the carminatives, purgatives, etc. I concluded, finally, that the disease being periodical in character, and not attended with fever, was neuralgic, and that I would give him the benefit of the great anti-periodic, quinine. After the first night the neuralgia of the bowels was *cured*, and did not return for fourteen days, when, as if by magic, it again vanished under the potent drug. I have used it in every case of this kind since, and with the same unvarying and gratifying success. I used the following formula.

℞ Quin. sulph. gr. ix.
Hyd. chlo. mit. gr. iii.
M. ft. chart. ix.

Sig.—One at 9, 12, and 3 each day.

—*Atlanta Med. and Surg. Four.*, June, 1887.

Hayem on the Treatment of Infantile Dyspepsia, Particularly that Accompanied by a Greenish Diarrhœa.—In his children's pavilion the author has seen many cases of greenish diarrhœa, and he first thought that hydrochloric acid gave the best results, although it often failed. Later he resorted to lactic acid with better results, but still that sometimes disappointed. He gives after each feeding a coffee-spoon of a two-per-cent. solution, which makes about 7 to 10 grains of the acid a day.

Hayem found that the admission of such a case into his wards was always followed by a regular epidemic of the disease. It has led him to have his interne Lesage search for some means of contagion, and he discovered the green color of the stools to be due to a microbe which is ingested with the food and thrives, particularly in a neutral or alkaline menstruum, while any acid, lactic particularly, hinders its development.

Hayem has experimented with different antiseptics, but finds that lactic acid acts better than any.—*La France Méd.*, May 19, 1887.

Harkin (A.) on the Treatment of Epistaxis by Counter-Irritation Over the Hepatic Region.—Dr. Alexander Harkin calls attention to the fact that he, in the *Lancet*, Oct. 30, 1886, described the method of treating epistaxis which Verneuil¹ recently advocated, being apparently not cognizant of Harkin's publication. Dr. Harkin says: "In illustration of my views, I gave the particulars of a case of vicarious bleeding from the under lip, which arose immediately after the deligation of hemorrhoidal tumors with excessive bleeding, ultimately cured by blistering over the liver; of a second example, in which dangerous and profuse hemorrhage from piles was immediately cured by a similar remedy; and then, in pursuance of my theme, appended the cases of three young men suffering from epistaxis, who were instantly relieved by blistering over the hepatic region. A remarkable case, which occurred during the recent riots in Belfast will further illustrate the subject. I found one of the men in bed with a handkerchief saturated with blood, which had flowed from his nose the greater part of the previous night. On satisfying myself of the nature of the illness, I painted the man freely with the liquor epispasticus over the region of the liver, prescribing no other remedy but rest in bed. On our revisiting the man next day, he informed us that from the moment the blister began to pain him the hemorrhage declined, and left him altogether a short time after.—*Lancet*, May 7, 1887.

Minot (F.) on the Treatment of Typhoid Fever by Antipyrin and Thallin.—The following conclusions were reached: 1. Both antipyrin and thallin

have a remarkable power of reducing the temperature in typhoid fever. 2. In no case was the use of these refrigerants apparently followed by any unfavorable effect upon the course of the disease. 3. The general condition of the patient was more comfortable after taking antipyrin and thallin, which were often followed by sleep. 4. The refrigerant medication by antipyrin and thallin appears to have no specific or decided effect upon the course or issue of typhoid fever. It often contributes much to the patient's comfort, perhaps indirectly promotes his safety. 5. The effect of antipyrin and thallin in promptly lowering the temperature, shows that the danger in typhoid fever does not consist in high temperature alone, and that the latter is rather an index of the violence of the abnormal condition which we call fever, though perhaps adding somewhat to the danger. 6. By the internal use of antipyrin and thallin, all the effects which are claimed for the treatment of typhoid fever by the cold bath are readily obtained without the trouble and inconvenience of the latter method, and without exposing the patient to the dangers of exhaustion and shock consequent on the fatigue of removal from bed. 7. These remedies may be given without danger to the youngest patients in suitable doses; and, indeed, their beneficial effects are more decided and the unfavorable consequences are less observable than with adults.—*Med. News*, June 11, 1887.

Martin (P. J.) on the Modern Antipyretics.—The author has studied experimentally the effect of certain drugs upon the fever produced artificially in animals by destroying a small area near the corpora striata where an inhibiting heat centre is thought to be located. His results are as follows:

Hydrochinon generally in full doses causes increased dissipation, the latter being greater. By this means the temperature is lowered. Small doses at times also decrease heat production and heat dissipation.

Antipyrin decreases heat production and increases heat dissipation, thus being an ideal antipyretic.

The thallin experiments demonstrate an increased dissipation, while half show increased production and the other half diminished production. The increase of dissipation is much greater than that of pro-

¹ See MEDICAL ANALECTIC, 1887, p. 268.

duction. These results prove that thallin reduces fever by increasing dissipation, while its effect upon heat production is variable even with the same dose.

In the experiments with kairin heat dissipation was increased in all except one, where it was slightly diminished. Heat production was diminished in the majority of the experiments. This drug reduces temperature by decreasing heat production and increasing heat dissipation.—*Therap. Gazette*, May 16, 1887.

Hamilton (A. McL.) on Antipyrin and Acetanilide in Headache and Epilepsy.—The former he gives in 15-, the latter in 5-grain doses. It would seem as if both remedies were of value in headaches or cerebral states attended by anæmia, or in the excitement due to cell malnutrition and exhaustion; and, though antipyrin seems to be the more serviceable remedy, it possesses drawbacks which do not belong to antifebrin. It would appear as if the remedies were valueless or even harmful in cases of organic or symptomatic epilepsy, but worthy of a trial in the light cases attended by rather general cerebral vascular spasm and not much muscular movement. In several cases of *petit mal* the good effect of continued doses of antipyrin and antifebrin is manifest, for the losses of consciousness are far less frequent than when the patients were under other treatment. The author has given to one patient forty-five grains of antipyrin in two hours without ill effects.—*N. Y. Med. Jour.*, May 28, 1887.

Baylor (G. W.) on Hydrocyanate of Iron in the Treatment of Epilepsy and Neuralgias.—Like many other preparations of the ferruginous type, hydrocyanate of iron appears capable to subserve quite a number of indications, though its predominant value is exhibited in the treatment of epilepsy. My attention was first called to this remedy in the treatment of epilepsy by Prof. D. S. McGugin, of the Iowa Medical College, in the supplement of the *Journal of Materia Medica*, in the year 1872, in which he cites a number of cases that were cured by this drug alone. I determined upon a trial of the hydrocyanate of iron in a case which seemed to demand such a combination, as his general system was in a bad condition, which is usually the case after a protracted course of treatment with the bromides.

I then put my patient upon the following :

℞ Iron hydrocyanate . . . gr. lx.
Pul. valerian . . . gr. cxx.

M.—Ft. pil. No. 120. Sig.—One pill three times daily after meals.

The dose was gradually and cautiously increased, so that at the end of three months my patient was taking eight grains of the drug daily. At the expiration of this time I had the pleasure to see my patient greatly improved; his appetite and digestion, which had been bad, now good; general health improved; he was no longer irritable and gloomy, but was sprightly and hopeful, and looked forward with confidence to an ultimate and permanent cure. The paroxysms, which had been frequent and severe, had entirely ceased. Treatment continued. Patient died about six months afterward from an intercurrent disease. I believe if patient had lived or been put upon the hydrocyanate-of-iron treatment sooner, that a permanent cure would have been effected. There is one thing sure in this case, that it controlled the paroxysms better and more effectually than any remedy that had been administered before. It possesses this advantage over the bromides, that it not only controls the paroxysms better, but it does not impair the general health of patient like the latter. Since that time I have administered this remedy to some eight or ten cases with decided success—about half of this number being cured; others, being old and chronic cases, were more or less benefited. It is an excellent remedy in the treatment of the various forms of neuralgias. It can be combined with sulph. of quinine, sulph. of morphia, or the extract of henbane, as each individual case may require. It exerts a powerful influence over the functions of the uterus, and when combined with the extract of belladonna, I know of no remedy better to relieve congestive dysmenorrhœa or irritation of the ovaries when of a neuralgic character.—*So. West. Med. Gaz.*, May, 1887.

Huchard on the Treatment of Angina Pectoris.—Referring to a fatal case of angina pectoris in which there was found to be a dilation of the orifices of the coronary arteries with narrowing and final occlusion of the vessels, the author cited a great number of observations going to prove the curability of the disease by the prolonged iodide treatment. He advises in all cases that the iodide of sodium be added to the iodide of potassium.

Ergot, digitalis, belladonna, cocain, kairin, antipyrin and acetanilide, are contra-indicated in this disease. The author thinks that spontaneous recovery from angina pectoris is very rare.—*La France Médicale*, May 5, 1887.

Taylor (R. W.) on the Use of Oil of Wintergreen in the Treatment of Gonorrhœal Rheumatism.—The author has treated twelve cases of this obstinate malady with the oil of wintergreen in from 10- to 20-drop doses three times a day. Out of these twelve cases prompt relief to pain was noted in ten, and a satisfactory result as to ultimate cure was reached in periods averaging from one month to ten weeks. An agent which, in such a rebellious and capricious disease, will give relief to pain so uniformly, should be entitled to consideration.

This agent will be found of most benefit in recent cases, in which the fibrous structures of joints and muscles are involved, and in which there is not a large amount of serous effusion. In cases complicated by hydrarthrosis the agent will be more or less disappointing, and when used in chronic cases it will not be found to be very reliable. In most of these cases structural changes have taken place, and these the oil of wintergreen is powerless to remove. Nor will it be of much service in relieving and curing that condition of cachexia into which these patients so frequently fall.

The drug, too, allays urethral irritation, which is a great advantage, since there is no doubt that the alkalies, iodides, and salicylates fail to produce a cure for the reason that their irritant action on the bladder and urethra necessitates their discontinuance.

One frequently has to use cooling lotions, counter-irritants, blisters, actual cautery, massage, immovable dressings, and other means as adjuvants.—*N. Y. Med. Jour.*, June 7, 1887.

James (W.) on the Prevention of Sea-Sickness.—Some years ago, whilst studying the feeling of dizziness, I was led to discover the singular immunity from it which deaf-mutes, as a class, possess; and, in an article published in the *American Journal of Otology*, for October of that year, I ascribed this immunity to the destruction either of the auditory nerves or of their labyrinthine termination. I found, moreover, in deaf-mutes, what seemed signs of a possible immunity from sea-sickness;

and ventured the suggestion that the semi-circular canals were probably the starting-point of that affection also, and that its symptoms in an ordinary sufferer might perhaps be alleviated by blistering or otherwise counter-irritating the skin around the ears. Later, I thought, that in crossing the English Channel I had prevented an attack of sea-sickness in myself by simply rubbing my mastoid processes with my fingers.

The editor of the *Gulf View*, of Ceder Key, Florida, in the number for April 2d, of that journal, gives the following interesting account of his own case: "In the year 1859 he received a blow from behind on the mastoid process, just behind the right ear, crushing the outer table of the skull and destroying the delicate nervous portion of the internal ear, including these same semi-circular canals alluded to as being absent or negative in deaf-mutes. The immediate consequences of the injury were, first, the most distressing nausea of a character identical with that of sea-sickness, which lasted with intervals of ease for two or three days; and, secondly, complete destruction of the function of the organ, the ear of that side being totally dead for ever after. Shortly after convalescence, the writer made a voyage to Cuba and back, in rough weather, exposed to a very rough sea for six days on the voyage over, and the same time returning, and to his agreeable surprise, though previously very susceptible, he found himself to be proof against sea-sickness, and the immunity has continued to this day, nearly twenty-eight years."—*Boston Med. and Surg. Jour.*, May 19, 1887.

Shattuck (F. C.) on Overdistension of the Right Ventricle with a Report of Six Cases Treated by Leeches.—In most cases it is impossible to remove the cause, and thus bring about permanent relief. The cause lies in structural changes, generally of the valves of the heart, which cannot be made good. Our efforts must, consequently, be directed toward establishing or restoring the compensation—that is to say, toward enabling the right ventricle to meet the demands upon it. This is to be done by either stimulating its power, or by lessening the demands, or by both at once. In the earlier and milder grades of muscular incompetency, when the congestion of the portal system is absent or slight and digestion remains good, stimulation by

heart tonics, combined with some moderation in the demand for heart power—rest and diet, with, perhaps, purgation—work to a charm. A proper balance of the circulation is struck anew, and every thing goes on well again for a longer or shorter time. In the higher grades of the condition, however, when portal congestion is great and the digestion much impaired, the usual means of stimulating the ventricular contractions fail us, partly by reason of impaired absorption, partly of sluggishness of the nervous centres, partly of feebleness of the muscular wall. Under these circumstances, mechanical relief is what is wanted, what is imperative. If a portion of the load can be lifted from the right ventricle, it may be able to recover itself; otherwise not. The withdrawal of fluid from the pleura or peritoneum is an indirect means of lifting a portion of the load, too indirect for extreme cases. The serum is outside of the circulation, and its withdrawal aids the circulation only by permitting greater functional activity of the abdominal organs or of the lungs, or by allowing serous transudation anew, and thus diminishing the mass of the blood in the veins. Free catharsis is another means, less indirect than aspiration, as the serum is derived immediately from the blood in the portal system. But it may be difficult to produce catharsis, on account of the failure of the gastric mucous membrane to absorb. We may wish, moreover, to avoid the fatigue incident to copious intestinal discharges, even when well managed. Direct means of lifting a portion of the load remains to us; the withdrawal of blood itself, either by venesection or by leeches.

There can be no question that, since bleeding fell into desuetude, lives have been lost, and suffering has been endured, which might have been spared had blood been drawn. In the class of cases which I am considering the amount does not need to be large, as a rule. It is surprising how much relief follows the abstraction of as little as eight ounces, the right ventricle immediately recognizing the lessened demand, and the heart, as a whole, then responding to the stimulus of a cardiac tonic. The relief to the right ventricle allows improved circulation, and the nervous centres are in better condition to react to the drug which the stomach will now absorb. Active purgation is also often now desirable.

The choice as between blood-letting by venesection or leeching may be, but is not generally, vital. The former is quicker, and, if it is desired to take a considerable quantity, then much preferable. But if eight or ten ounces are sufficient, a dozen leeches and a little poulticing will do the work, and there is less prejudice to overcome on the part of the patient and the friends. During the past year I have employed or advised leeching in six cases of over-distended right ventricle, five in hospital, and one in private practice. These cases I will now report as briefly as possible, neglecting all features which do not have a direct bearing on the matter in hand.

One case received no benefit, but my only misgiving is that enough blood was not drawn. Two were greatly relieved for a time, but succumbed to disease, which, post-mortem examination showed, admitted of nothing more than temporary palliation. Of the other three cases, two are known to be alive; the third has been lost sight of. Of these three, two would, in my opinion, not have lived more than a few days if I had not drawn blood. Some of the impressions which one receives at the bedside are difficult to convey to others in words. The change which I saw in some of these cases from one day to the next is deeply fixed in my mind, and, I think, also in the minds of the other gentlemen, and of the nurses who were watching the cases.

In short, when the right ventricle is gorged with blood, the leading indication is often to withdraw blood from behind (the hepatic region), alcoholic stimulants being given simultaneously by the mouth, or under the skin, as the features of each case demand.—*Boston Med. and Surg. Jour.*, April 28, 1887.

Teale (J. W.) on Stretching the Sphincter in Apoplexy.—The patient was a woman of sixty-four, in poor general health, mentally depressed and suffering from impaction of fæces. About 6 A.M. on July 8th, whilst on the night-stool, her maid noticed her face twitching, and, on getting her into bed, she said that these twitchings increased until they amounted to violent convulsions, which continued at intervals. I was sent for, and saw her at 6.50 A.M. I found her with slight but well-marked symptoms of paralysis of the left side of the face, which gradually became more decided in character, extending to

the left arm and leg. The pupils were regular, somewhat contracted, slightly sensitive to light. There was no stertor, but insensibility was complete. Every few minutes there was a convulsive attack, commencing with twitchings of the left side of the face, extending gradually to the left arm and leg, and then becoming general over both sides of the body, and gradually relaxing, without pursuing any definite order. A copious enema of soap and water and olive oil was given, which was retained. At 10 A.M. the enema was still retained; the convulsive attacks continued every few minutes, were more frequent and violent, and insensibility complete. On examining per anum, hardened fæces could be felt floating about in the enema fluid, though, even in her insensible condition, so tight was the sphincter that the finger could only be passed through it with difficulty, nor would it allow a drop of fluid to escape.

In this insensible condition no ether was required, so I stretched the sphincter freely. Immediately the enema fluid poured out, followed by a copious mass of offensive fæces of various stages of antiquity. The convulsions continued pretty regularly until 1.30 P.M. Urine was examined and found highly albuminous. On the next day she regained consciousness and finally slowly recovered, a slight left hemiplegia remaining.—*Lancet*, May 21, 1887.

Da Costa (J. M.) on the Treatment of a Case of Cerebral Apoplexy.—When admitted, twenty ounces of blood were taken from the patient's arm with evident benefit, and cotton oil was given, which purged him freely. One drop of tincture of aconite was given every second hour at first; four days later he was given potassium iodide, a scruple four times daily.

He has recovered power to a very considerable degree, and the leg is regaining strength even more than the arm. Some facial paralysis remains. He has now reached the stage for local treatment, massage, friction, and stimulation of the muscles by the use of mild faradic currents.

It is always a nice question when to begin this local treatment after apoplexy. It is better to begin rather late than early; to wait until voluntary power commences to return in the muscles. If it is begun too early we run the risk of increasing the

brain-lesion. Later still strychnine is useful. Harm is done by using ether too early.

The patient has reached a stage in his history when the brain-malady is not active, and we will therefore use massage daily and electricity every second day.—*Med. Times*, May 28, 1887.

Mason (L. D.) Notes on Voluntary Passive Motion in Cases of Paralysis of the Extensors of the Forearm.—

In cases of paralysis of the extensors of the forearm, lead palsy or dropped wrist (so-called), the inability of the patient to move his wrist is a source of marked mental depression. Otherwise in apparent good health, he is deprived of his only means of support, his hand is powerless, and he is as effectually crippled as if he had not any hand. The slow progress of his case still further increases his despondency. Now if by any means we can cause the patient to move freely his paralyzed wrist (paradoxical as the assertion may appear), we have made an impression not only for good on the mind of the patient, but we have also actually made an advance in the treatment of the case.

The method is a simple but effectual one. The patient is requested to supinate his forearm; the palm of the hand is thus turned upward, the back downward. At the same time, as the position of supination is somewhat tiresome, he is directed to support the affected arm just above the wrist with the opposite hand. He now flexes the wrist upon the forearm—this he can readily do of his own volition; he then, when the wrist is at extreme or moderate flexion, relaxes the flexors, and the hand falls back to its original position of extension, *gravity* being the factor that causes it to fall back. The position of flexion of the wrist is again assumed, and again *gravity* causes the hand to fall back. Thus the patient practises passive motion whenever he chooses to do so, or according to the direction of his medical attendant. We have thus by this simple method of *voluntary passive motion* in a partially paralyzed limb secured a valuable adjunct in the treatment of a class of cases oftentimes tedious in the extreme both to the physician as well as the patient, and in which we are glad to accept the slightest hint that may prove of service in the treatment.—*Four. Nerv. and Mental Disease*, May, 1887.

Mann (J. S.) on Abortion Following the Use of Potassium Permanganate.¹—Last July a colored woman applied to me for treatment, and stated that her menstrual periods had never been regular before marriage, and during the three years she had been married she had gone three months at a time without menstruating. At the time she applied to me it had been one year since she menstruated the last time, but during that time her general health had been very much depreciated. I at first gave her tonics, thinking, perhaps, by building up her general health it would set things aright. After keeping her on the tonics for some time, I found she derived no benefit from the treatment as regards the menstrual periods, although her general health was greatly improved. I then put her on permanganate of potassium, 2 grains three times a day (having no idea that she was pregnant). After she had been taking it a few days I was summoned to see her, and upon my arrival I found that she had aborted, and the foetus looked to be about two months old. —*Therap. Gazette*, May 16, 1887.

Vroz (I) on Permanganate of Potassium in Chronic Malarial Affections.—Most of the inhabitants of the district where I practised [Island of Dominica] lived in thatched huts, badly ventilated, with the natural soil for the floor. As the country abounds in rivers, and rain is constant, they were very damp. The food eaten consists of carbohydrates and boiled fish—a diet which, with their surroundings, certainly renders them unfit to resist disease. I was summoned by women with fever and amenorrhœa or dysmenorrhœa due to exposure, and malarial anæmia or toxæmia. It was to them that I first administered permanganate of potassium, and it cured them not only of their uterine symptoms, but of their malarial fever also. I afterward gave it to men and children, and with very interesting and successful results. The usual dose was from half a grain to a grain, in water, three times a day. In private practice I give five grains of pepsin after the dose, to prevent the nausea, which is the only drawback to the use of the drug. Since my appointment as medical officer of the Virgin Islands I have been using the same treatment here with good results. I have not heard or read of

its having been used before for malarial fevers. As to the *modus operandi* of the permanganate I will say but little, and that what I know—namely, that, as a germicide, it is one of the best, and one that is harmless even in strong solutions.—*N. Y. Med. Jour.*, May 21, 1887.

MEDIGINE.

The Hour of Parturition.—An old interne of the Maternité Ste Anne has studied the records of 1,000 labors in that institution to determine if possible the hour at which most children are born. His results are as follows:

Between 8 A.M. and 8 P.M. there are recorded 450 or 45 %, and between 8 P.M. and 8 A.M. there are 550 or 55 %.

Between 6 A.M. and noon	239 or 23.9 %	} 45.9 %
From noon until 6 P.M.	220 or 22. %	
" 6 P.M. until midnight	272 or 27.2 %	} 54.1 %
" midnight until 6 A.M.	269 or 26.9 %	

These figures confirm a common opinion, that more births occur by night than by day.—*Four. des Sci. Méd. de Lille*, April 29, 1887.

Besnier (J.) on a Case of Puerperal Peritonitis with Successful Removal of Five Litres of Pus.—The patient, a woman of twenty-six, had had two miscarriages. She became pregnant for a third time, and the fourth day after a normal labor she was seized with symptoms of peritonitis; chills, fever, the vomiting of greenish material, and tympanites.

After the disease had run a chronic course of eight weeks, a medium-sized trocar was introduced as for ascites, and five and one-half litres of purulent fluid escaped. Proper support was of course given to the relaxed abdomen, and subsequent applications of iodine and collodion were made.

Complete recovery supervened.—*L'Union Méd.*, May 19, 1881.

Mays (T. J.) on the Chest Movements of the Indian Female.—From the author's observations it obviously follows that, so far as the Indian is concerned, the abdominal is the original type of respiration in both male and female, and that the costal type in the civilized female developed through the constricting influence of dress around the abdomen. This is markedly shown in the greater prominence of the costal movements in those girls who

¹ See MEDICAL ANALECTIC, May, 1887, p. 205.

were either one half or three fourths white, and who were hence dominated to a greater or less extent by the influence of civilized blood. While these tracings were being taken, an incident occurred which demonstrated that abdominal constriction could modify the movements of the thorax during respiration. At a visit to the institution he obtained an exceptional costal type of respiration from a full-blooded Indian girl. At his next visit he concluded to repeat this observation, and found that, contrary to his instructions concerning loose clothing, etc., this girl at the first visit had worn three tight belts around her abdomen. After these were removed she gave the abdominal type of breathing which is characteristic of nearly all the Indian girls.—*Therap. Gaz.*, May 16, 1887.

Webber (S. G.) on Two Cases of Insomnia.—Miss A., aged fifty-four, had never been well after having the measles at eighteen years of age. During winters she had been subject to colds, feeling "stuffed across the lungs." She never thought she had any nervous trouble until four years ago, when she received a shock from the sudden death of her mother, who was sick only one day. Her father is alive and well, eighty years of age.

After her mother's death she had the care of house-keeping; also looked after a small business of her own. She then began to have restless nights and "spells of nervousness," in which she would shake or tremble all over. She slept very little, and often could not lie down. She had considerable dyspepsia, distress soon after eating, acidity, and heartburn. After poor nights she had distress in her head and headache.

She had taken paraldehyde for many weeks, with the result of giving sleep, and with seemingly no bad effect. The quiet and freedom from home cares at first had a very beneficial effect, and sleep was more natural. Later, for a while, she slept well after taking two grains of quinine at noon and at bedtime. There was much disturbance and loss of sleep, caused by two or three attacks of looseness of bowels, with some colic, possibly ordinary summer disturbance, or of nervous origin. Occasionally it was necessary to give a dose of paraldehyde at night, but not frequently. On the whole, however, the sleep was very poor, and these remedies were of only temporary benefit.

It was noticed that the skin was harsh and dry, and she scarcely ever perspired. A warm pack was given at bedtime for several nights. At first this did not produce perspiration, and when the temperature of the pack was reduced, it had no effect until a dose of pilocarpin was given with it. When perspiration was free the sleep was natural and refreshing. After eight days the pack was omitted. The pilocarpin, half a grain by mouth, was continued at bedtime. On the tenth day after trying the above treatment it is recorded: "Skin has a more natural feeling. She is better; is improved in appearance; has gained in flesh. Stomach don't give so much trouble. Can stay in room, and lie down with more comfort than for a long time."

The pilocarpin was reduced to one sixth of a grain, and after two weeks it is recorded: "Patient is decidedly better. Sleeps five to six hours on an average, almost always without extra help. Can lie down with very much less discomfort." The urine was natural, acid, sp. gr. 1.018, without albumen or sugar.

In this case there seems to have been an intimate relation between the loss of function in the skin and the sleeplessness. Whether both conditions depended upon the same cause, or the loss of power to sleep was the result of diminished cutaneous action, may be questioned. She was not seen until the two conditions had been of so long standing that I will not venture to decide the question. The power of sleeping was recovered in proportion to restoration of the function of the skin.

Miss C., aged twenty-two, was never very well, though, from eleven to fourteen years of age, she enjoyed very fair health. The patient's father and father's family were very healthy; her father died some years ago. Her mother is alive, a very nervous woman, and has severe headaches and neuralgia, and is a poor sleeper. The mother's mother is not well. One of her mother's sisters is insane.

At about fifteen years of age she was obliged to leave school. For two years previously she had not slept much. She was confined to her bed, and could see no one, except her mother, without screaming, laughing, and crying. Her head felt badly, and her back troubled her all the time. At times her legs ached, and she had pains in the joints. For two weeks before I saw her she had slept well.

The pupils acted naturally ; the eyes, face, tongue, and limbs moved naturally. There was no trembling of hands ; they were rather moist, as were also the soles of the feet. There was lack of strength. Sensation was natural. Plantar reflex was slight ; patellar-tendon reflex was natural. Heart and lungs were in a normal condition. There was no tenderness over the spine, but pressure on the muscles either side of the spinal column caused some discomfort.

After about two weeks she had an hysterical attack. Said she could not breathe ; had much distress, agonizing for breath. Screamed two or three times, loud enough to be heard all over the house. Had pain in back, but head did not ache.

The chief unpleasant symptom was sleeplessness. When she could sleep her head felt comfortable ; if she lost sleep she had more discomfort in her head. She was dressed and about the house most of the time ; went out-doors, but was not able or not inclined to take much exercise.

Various means of inducing sleep were tried—rest in bed, hot baths, warm packs, cold douches to back, diet—but with only temporary success. Various hypnotics were used, with varying results. Paraldehyde would produce sleep one night, not the next. Urethane did no better. A pill containing camphor and lupulin caused sleep several nights. One containing camphor, extract of hyoscyamus, and extract of valerian also gave several nights' sleep, but both these, finally, had little effect.

On account of the distress in her head and headache, aconitia was used, in a dose of two-hundredth of a grain. Not only was the head relieved, but that night sleep was much more natural and refreshing. The aconitia was afterwards given frequently at bedtime with favorable results. It did not produce sleep every night.

About a month later, there being more distinctly marked pelvic disturbance with increase of headache, another examination was made, with a speculum. The hysterical excitement was less, or rather there was more self-control, possibly because sleep had been better. The cervix was quite large, the canal bled very easily, the cavity of the uterus was a little longer than normal, there was considerable excoriation around the os, thick mucus extruded from the os. Tincture iodine and glycerine were applied. About a week later another

application was made, and one or two more in the next month. The congestion and excoriation were much relieved. The headache and backache were better, and the patient slept much better. For a month she had only one or two sleepless nights ; hypnotics were not given during a part of this time.

Hypnotics were only of temporary benefit, and the milder kinds were of more continuous service than the stronger. The influence of the uterine disease upon both the headache and sleeplessness was clearly defined. No remedy proved of much value until that was treated ; the best results were obtained by combining with such treatment, aconitia, which restored the tension of the blood-vessels.—*Boston Med. and Surg. Jour.*, April 14, 1887.

Sachs (B.) on the Treatment of Functional Insomnia.—Summarizing the experience I have had in cases of functional insomnia seen during the last year or more, I find that I have used for treatment chloral and bromide, the bromides separately, the amorphous hyoscyamine, paraldehyde, urethan, and, in a single instance, hypnone. Morphine I have never used in these cases, as I object to it in all cases in which there is not severe pain, and certainly object to it in such cases as these, when the patient would be quite prepared to contract the habit. The bromides alone have been of occasional service to me, if given in one half to one drachm doses, in cases of extreme restlessness ; but even in these I have learned to substitute amorphous hyoscyamine in doses of about one twentieth of a grain, repeated every three hours.

I object most strenuously to the plan advocated by Dr. W. A. Hammond and others, of keeping these patients for a long time under the influence of the bromides. These neurasthenic patients require all the will power they can possibly command, and are in much greater need of tonics than of bromides. It is easy enough to bring about a condition of semi-stupor in such patients, but that is not equivalent to bringing about healthful sleep.

Paraldehyde I used freely about nine months ago, and for several months later. I gave it in doses of one to one and a half drachms, in claret. This does was always sufficient to bring about sleep the first few nights, but if required beyond this time, the drug proved unsatisfactory, as the hypnotic dose had to be increased.

Urethan has been satisfactory in a number of cases. It has no disagreeable after-effects, and dose not irritate either stomach or bowels. It has been my experience that the dose should be between thirty and forty grains, and that greater quantities of Merck's preparation induce wakefulness rather than sleep.

The mixture of fifteen grains of bromide and twenty grains of chloral has often come to the rescue when every other hypnotic refused to act. I have seen no ill effects follow the exhibition of this mixture, even in cases of weak heart.—*Med. News*, May 28, 1887, in *Med. and Surg. Reporter*, June 4, 1887.

Thompson (W. H.) on the Treatment of Epilepsy.—Whereas the writer had formerly often felt discouraged with the therapeutics of epilepsy, he was now growing less so. The first indication to be met was to supply nerve nutrition, and the best agent for this purpose was cod-liver oil. He tried this remedy in every case of epilepsy as persistently as in phthisis. It also tended to prevent impoverishment of blood by the bromides. Another tonic was phosphorus. In diet, animal food was excluded to a large extent. Carnivorous animals had convulsions oftener than the herbivorous, because flesh as a diet predisposed to convulsions. Rapid eating should be guarded against. Sensory nervous instability should be met, and it was not necessary to dwell upon the value of bromides, as no physician would treat epilepsy without them. If there were indications of persistent cortical irritation, he gave corrosive sublimate, and sometimes rubbed in the oleate of mercury. He used belladonna in every case in which there were symptoms pertaining to the digestive tract. Chloral hydrate was called for at night in some cases. Digitalis was indicated when there were pronounced vascular symptoms, or symptoms referable to the genito-urinary tract.—*N. Y. Med. Jour.*, May 7, 1887.

Money (A.): Will the Knee-Jerk Divide Typhoid Fever from Meningitis?—As a result of careful study on this subject, the author concludes that the differential diagnosis of meningitis from mere fevers might be assisted far more by the state of the knee-jerk than by the swelling of the spleen; for unless the splenic enlargement be enormous, tubercular as well as typhoid fever and other diseases—*e. g.*, pyæmia—will account for the splenic

swelling; whereas absence of the knee-jerk, or, rather, ascertained disappearance of the same, is practically never met with as the simple outcome of prolonged pyrexia.—*Lancet*, May 21, 1887.

Teissier (J.) on Mal Perforant of the Aortic Valves in Ataxics.—In one of the patients observed there was a diastolic murmur at the apex and a pulse-tracing denoting perforation of the aortic valves. The second case had been attacked with hemiplegia and descending degeneration, the subject dying suddenly with perforation of the intestine.

Upon autopsy there was found in both instances a perforation of an aortic valve.

These cases seem to point to ataxia as a cause of perforating lesions elsewhere than in the hand or foot.

The author formerly published a case of perforation of the œsophagus in an ataxic.—*Lyon Méd.*, May 8, 1887.

Hogben (E.) on Brass-Workers' Disease.—The symptoms of an acute attack of this malady manifest themselves in the following order. A few hours after the brass-founder has been at work in the casting shop, he experiences a sense of languor and oppression, with headache, nausea, and muscular pains. Vomiting often occurs, and a cold stage comes on, the rigors and chattering of the teeth being sometimes well marked. After an hour or two there follows a hot stage with slight febrile reaction, and subsequently profuse sweating. The hot stage is not well marked, the temperature at no time much exalted, but the sweating is nearly always profuse and prolonged. Young men appear to suffer more from the acute attacks, which are more severe in foggy weather and in ill-ventilated shops. Slight causes, such as a cold bed, wet feet, or a catarrh, predispose to these ague-like paroxysms.

There is to be observed in almost all patients who are brass- or copper-workers a distinct green line or band on the neck of the teeth, between the crown and the insertion in the gum, sometimes extending half way over the crown of the tooth. This green mark varies from a bright color to a greenish-brown; it is seen best on the teeth of the upper jaw. The edge of the gum is often slightly blackened, but the general appearance is quite unlike that seen in chronic lead poisoning. This stain, which is very commonly detected in brass-workers of every description, has been as-

certained to be due to the presence of copper. Another remarkable sign is found in the fact that the copious perspirations of brass-founders are often stained green, and actually impart their tinge to the underclothing. The axillary sweat frequently can be observed to stain the undershirt a green color. White-haired, elderly brass-workers often present the curious phenomenon of a greenish tinge distinctly recognizable in their hoary locks. I have visited a factory where I was told all the old men had greenish-white hair.

Most prominent among the early symptoms are dyspepsia, loss of appetite, gastrointestinal disturbances, nausea, vomiting, metallic taste, thirst, colic, constipation, and diarrhoea. We observe many sensory phenomena, including a general feeling of "nervousness," headache, oppression, neuralgia, pleurodynia, pain over the liver and between the shoulders, lumbago, and pains in the calves. A sharp pain in the left side, with a sense of constriction in the thorax is frequently complained of. The pain is referred to the heart, and there is some dyspnoea with pallor and anæmia. Cough, chronic pharyngitis, and loss of voice are very usual. I am told that an unusually large proportion of brass-workers are deaf. Chronic bronchitis and emphysema are the result of the irritant atmosphere in which the men work. Gout and chronic nephritis prevail largely. There is generally a disinclination for active exercise, and in more advanced cases paresis of the legs. Tremors are often noticeable, but I have not yet seen a case of true paralysis agitans in a brass-worker, although it has been said to be common amongst the class.—*Birmingham Med. Rev.*, May, 1887.

Ayer (J. B.) on a Third Attack of Scarlet-Fever. Remarks upon the Recurrence of Eruptive Diseases.—The patient was a boy whose brother had had two attacks of scarlet-fever. *First attack*, at age of five, was severe, involving the skin, mucous membranes, glands, and membrana tympani. *Second attack*, six years later: Typical skin eruption and desquamation; catarrhal symptoms present, but less marked. Relapse and sequelæ due to debility. *Third attack*, seven months later: Skin as in second attack; mucous membranes slightly affected; pseudo-relapse. Though the mildest of the three attacks, it was too severe to be classed under the "rudimentary forms" of scarlet-

fever.—*Bost. Med. and Surg. Jour.*, May 19, 1887.

Boucheron on Cyclitis Minima of Rheumatic or Gouty Origin.—The symptoms of this affection vary as the rheumatic process attacks the ciliary muscle, nervous plexus, or vessels, or the processes or its secreting epithelium, or all these elements at a time.

The symptoms are as follows:

A pain on pressure over the region of the ciliary processes. A moderate spontaneous pain in the same region, coming on in paroxysms, sometimes with neuralgic irradiations, under the form of migraine or headache. Troubles of accommodation due to excessive or irregular contraction of the ciliary muscle. Slight and transitory elevation of ocular tension. Sometimes floating bodies in the vitreous, with an exudative cyclitis in the region immediately behind the crystalline lens. Sometimes the congestion of the processes gives rise to a slight hemorrhage into the vitreous. Some photophobia is present.

Articular or muscular attacks of a rheumatic or gouty nature alternate with, or coincide with, these symptoms of cyclitis. The duration of an attack is very short, but relapses are frequent.

The treatment consists locally in the use of mydriatics and cocaine in small doses, heat, rest for the eyes, and smoked glasses; internally the salicylates, salol, iodoform, quinine, colchicine lithine, alkalies. A rather non-nitrogenous diet, the avoidance of alcohol, out-door exercise, are advisable, and glasses to correct the ametropia.—*La France Méd.*, May 7, 1887.

PATHOLOGY.

Prudden (T. M.) on Bacteria in Ice, and Their Relations to Disease, with Special Reference to the Ice-Supply of New York City: an Experimental Study.—The paper was based on experimental study by the new method of water analysis which had to do with its living contaminations: the so-called biological analysis. It was not to be inferred that this method was intended to supersede the chemical. They were in most cases mutually supplementary; but so far as a certain class of diseases which might be transmitted by water, such as typhoid fever and cholera, was concerned, it was safe to

say that the biological method was by far the more important. The method was very simple, but it required for its execution considerable patience, care, and experience. The following was a summary of his investigations :

If he had accomplished the primary purpose of the paper, he had shown that by the biological analysis of water and of ice we could detect with great certainty the presence of bacteria, some species of which could give rise to serious disease, but that, when we had determined the number of bacteria present in water or ice, a careful consideration of other conditions was still imperative in order to determine whether the water or ice was fit for use.

He had shown that the popular impression that water purified itself in freezing was only partly true so far as the bacteria were concerned. The partial purification from bacteria was accomplished not by their expulsion from the water, but by the death of a certain proportion of them ; so that, if the bacterial contamination of the water was extreme, or was largely made up of the more hardy species, the ice formed from it, even though quite transparent, might still contain a large number of the living germs.

He had shown that different species of bacteria possessed different degrees of vulnerability to the action of low temperature. Certain species which were capable of causing serious and even fatal diseases in man—the bacillus of typhoid fever and the common bacteria of suppuration, for example—were capable of resisting a prolonged low temperature with the destruction of a part only of the individuals thus exposed. In the case of the typhoid-fever germs the exposure had lasted seventy-seven days.

He had shown that the resisting capacity of the different species varied with the vitality of the individuals, the degree of temperature, and the time of exposure, and that alternate freezings and thawings sufficed to exterminate completely in a short time all species experimented on, even those which could endure for a long period a sustained low temperature. Data had been gathered which seemed to justify the conclusion that in the freezing of natural waters there might be a purification from bacteria amounting to as much as ninety per cent. We had learned that the effect of freezing on water containing bacteria

was comparable to that of filtration, but with this vital difference : that whereas by filtration all forms of bacteria were removed in approximately equal ratio, by freezing, which acted as a sort of selective infiltration, some of the most dangerous forms might be retained while others were destroyed.

He had shown that New York City ice came from a series of naturally excellent lakes and ponds, and from a great tidal river rich in sewage-pollution. He had shown that while the conditions in the upper Hudson did not seem during the ice-forming season to be such as would favor purification from organic matter by oxidation, they did seem to be theoretically—and were shown to be practically—favorable to a considerable degree of spontaneous purification from bacteria by sedimentation ; but the limits and extent of this purification were yet to be made out.

Coming to the actual analysis of the ice from both the river and the lakes and ponds, he found a much greater number of bacteria in the snow-ice than in that which was clear or moderately bubbly. He found that the species of bacteria were much more varied and abundant in the river ice than in that from other sources, while in both there was a considerable proportion of the relatively harmless water-bacteria. He found that while the number of living bacteria varied greatly, not only in different parts of the same block of ice, but also in ice in different parts of the river and from different lakes and ponds, the average number was considerably greater in ice from the river than from lakes and ponds, even when Albany ice, which was worst of all, was excluded from the estimate. He had shown also that the average number of bacteria in ice from all sources taken together was far beyond the general standard which even a moderate degree of purity would allow.

The measures which might be adopted in view of the present condition of affairs were of two kinds : first, such as would come under the supervision of health officers ; second, those which belonged in the province of individual consumers.

In the first place, it would seem necessary that the State Board of Health or some other authorized body should be placed in charge of the ice-harvesting fields, and, by a system of inspection not less strict than that which should exist in the case of the

ordinary water-supply, determine which, if any, of the sources of ice-supply were so situated as to imperil the health of consumers of ice. In view of what had been seen, this would appear to be comparatively simple in all cases except that of the Hudson River. Here it would be necessary to establish by a most thorough scientific examination the distances from all sources of sewage-pollution at which it might be safely assumed that the water had freed itself from bacterial and other impurities sufficiently to form safe ice. It might in this way be possible to remove any chance of danger by permitting the questionable or bad ice to be sold only for cooling purposes, if such a classification were practicable, and thus not materially interfere with the interests of the ice-companies. A compulsory system of disinfection of excreta in infectious diseases might be instituted.

When we consider the precautions which the individual consumer might adopt, it is evident, from what has been seen, that if he could be certain that his supply came only from the lakes and ponds he would secure for himself a fair degree of immunity from danger. He might avoid ice cut in the vicinity of Albany. Snow-ice should be used only for cooling purposes. A variety of devices might be adopted in the use of ice for the cooling of drinking-water, such as pitchers containing receptacles for the ice, in the cooling of the water in refrigerators, also by making ice artificially from pure water.—*Phil. Med. Times*, April 14, 1887.

Mauriac (C.) on Renal Syphilis.—The form of nephritis caused by precocious syphilis is the parenchymatous. The symptoms and complications are those of ordinary Bright's disease. Some cases prove fatal, but the disease is not so serious as tertiary renal disease. Specific treatment, particularly KI, has a decided curative action and is often of much diagnostic value.

The late syphilitic lesions of the kidney are almost all interstitial or atrophic. Gummy and amyloid degeneration is often present. Hepatic syphiloma sometimes co-exists in the same subject. The symptoms and course of these cases are like those of chronic Bright's disease. In both these conditions mercury is often imperfectly eliminated by the kidneys, and salivation frequently occurs. KI suits these cases better, and is generally curative when

given in large doses. Besides specific remedies the ordinary treatment of Bright's disease should not be neglected.—*Rev. de Thérap.*, April 1, 1887.

Haig (A.) on the Relation of a Certain Form of Headache to the Excretion of Uric Acid.—Meat and cheese were taken with the object of bringing on a headache, for purposes of experiment. The relation of this headache to the excretion of uric acid at first appeared equivocal, but definite results were obtained on separating the urine excreted during the headache from that before and after. There appears to be retention of uric acid before the headache, excessive excretion during the headache, and diminished excretion after the headache. The excess during balances the diminution before and after; there is no absolute excess of uric acid; hence the previous equivocal results. During a headache there is little or no alteration of the excretion of urea. The theory which best explains every thing in this connection is that of diminished alkalescence of the blood. A dose of acid, either introduced from without or formed internally, may cause temporary retention of uric acid, and so lead to headache. Beer will do this. Retention possibly does not explain every thing, as the excess during headache appears to exceed the previous retention. There may be temporary excessive formation as well, hence the good effect of salicylate of soda, which diminishes the formation of uric acid. The good effect of a meal on this headache is due to the fact that it increases for a time the alkalescence of the blood. Hence also the good effects of a somewhat vegetarian diet and alkalies in its treatment.—*Lancet*, May 28, 1887.

Charrin and Roger on the Toxicity of Urine among Different Animals.

—According to these authors the rabbit secretes per kilo in twenty-four hours urine enough to poison 4.284 gm. by weight in its own species, 5.663 gm. in the guinea-pig, and 3.317 gm. in the dog; while under the same conditions the urine of man is only toxic to 4.61 gm.

They have proved that inanition lessens notably the toxic power of the urine, which oscillates about 1.609 gm. for the rabbit and guinea-pig. Under milk diet the urine rapidly becomes less poisonous and never passes the limit of 1.600–1.800 gm. *Le Tribune Medicale*, March 20, 1887.

Godlee (R. J.) on a Case of Obstruction of One Ureter by a Calculus, Accompanied by Complete Suppression of Urine.—A man of thirty-one was attacked June 4, 1884 with frequency of micturition and pain in the bladder. A week later sickness began and right renal pain, with fever and hæmaturia. There was pus in the urine. After a few days these symptoms subsided, but they soon returned and became worse. Intense tenderness appeared in the right loin, and the urine became highly albuminous, and contained large numbers of hyaline and granular casts as well as masses of bacteria, but it was never putrid. On July 13th a deep-seated perinephritic abscess was opened. The kidney could not be discovered. The casts disappeared completely from the urine, and the albumen diminished to a very small quantity. No urine escaped from the wound, which healed without trouble. The patient after this remained well, with the exception of occasional attacks of colic, till Dec. 10, 1885, when an attack of great severity set in, for which he took several hypodermic injections of morphia. On the 14th complete suppression of urine occurred, and lasted a week. No operation was undertaken, because it was assumed that there was only one working kidney, the ureter of which was blocked. On the 19th, however, the left kidney was felt and punctured, but the pelvis was found to be empty. On the 21st he began to pass highly albuminous urine, and the amount and character of this became more and more normal; but he did not rally, and died exhausted on the 26th. At the necropsy the right kidney was found to be dilated into a loose bag of pus, and a stone was impacted half way down its ureter, which was dilated throughout its whole extent. The left kidney was large and comparatively healthy, but showed signs of chronic interstitial nephritis; the pelvis and ureter on this side were normal.—*Lancet*, March 26, 1887.

Vaquez on Vulvar Eczema and Spontaneous Gangrene of the Penis among Diabetics.—The first-named lesion occurred in a woman of 57, diabetic for two years. She was passing 360 gm. of sugar a day. Local treatment with alkaline baths and lotions and talc powder and general treatment reduced the sugar to 65 gm. a day. The latter lesion oc-

curred in a man of forty-six who was passing 154 gm. of sugar a day, and consisted in a gangrenous sore on the under surface of the glans which was quite destructive. The spread of this was checked, but later a gangrenous sore broke out on the patient's right leg.—*La France Méd.*, April 21, 1887.

Haldeman (F. D.) on Unusual Metastasis in Mumps.—The first case was a man of twenty-eight. Inflammation of both parotid glands, and swelling of the left testicle. On the sixth day he developed an embolic pneumonia which proved fatal on the eleventh day.

The second case was also a man of twenty-eight, with implication of the testicles on the fifth day, who developed an endocarditis on the eighth day. Recovery took place with atrophy of the left testicle.

The third case was a man of twenty-one, with swelling of the testicles four days after the appearance of the mumps.

The third case occurred in the practice of Dr. Klinker and is as follows: Mr. N., aged twenty-one years, had an attack of mumps which dated from January 13, 1886. Both parotid glands were affected, and five days afterwards both testicles became tender and swollen. On January 19th the swelling in both parotids began to subside and a feeling of weakness, with a tendency to syncope, followed; that evening he had a chill, and soon afterwards a high fever. On January 10th Dr. Klinker was called, and found his temperature 103°, pulse 120 and very weak, profuse perspiration, pupils widely dilated, tenderness over liver with constant pain in that region; tongue coated with a light fur; *partial paralysis* of right upper and lower extremities. Did not see patient again until January 23d. The temperature at the time was 104°, pulse 130, profuse perspiration, with hurried breathing; right hypochondrium tense and painful on pressure, very distinct jaundice; the paralysis had changed to the left upper and lower extremities. The right thigh became very much swollen at this time, and an abscess formed, which was not opened.

January 26th. Patient semi-conscious, and breathing with great difficulty. During an effort to cough, there came a large gush of dark purulent matter, which filled the mouth, throat, and lungs so as to produce immediate death by suffocation.

The fourth case was a woman of twenty,

seven months pregnant. She was taken with the mumps on April 1, 1886. April 5th the swelling suddenly left parotid glands, and she became very nervous and weak; complained of pain over the hypogastric region. Dr. Klinker reports that at this time her temperature was 104°, pulse 120 and feeble. There was pain and tenderness over the womb, with constant vomiting. Her fever continued high throughout her illness.

April 10th. Active labor pains set in, and she was delivered of a seven-months' foetus, which had evidently been dead several days. The placenta came away, and with it a very profuse and *offensive* discharge. The patient became delirious, and died April 12th.—*Four. Am. Med. Ass'n*, May 14, 1887.

Taylor (H.) on Parotitis after Injury or Disease of the Abdomen or Pelvis.—My case occurred thirty years ago, and was that of an infant with imperforate anus, on which I operated on the third day after its birth, having to cut through more than one inch of tissue before I reached the rectal *cul-de-sac*. The child was completely relieved, and continued to do well for about a week, when the right parotid gland began to swell, evidently causing pain and inability to take nourishment, so that it sank in a few days.

In default of any better theory to account for the coincidence, I was led to think that I might have wounded the seminal vesicles in the operation, and that these organs might have the same relation with the parotid gland as the testicles.—*Br. Med. Jour.*, April 16, 1887.

Shattuck (F. C.) on Tubercular Peritonitis; Sloughing of the Umbilicus, and Fistula.—P., twenty-four years of age, entered the hospital June 21st. A sister died of phthisis. About a year before entrance the patient began to suffer from attacks of abdominal pain, distension and tenderness, lasting five to ten hours, and relieved by bilious vomiting. These attacks recurred at intervals of about a month. The last was four weeks before entrance; he did not rally from it, but felt poorly, lost flesh and strength, and had moderate diarrhoea much of the time. He had no cough or other pulmonary symptoms. Pulse 100.

Physical examination showed slight consolidation of the right apex without softening. In the umbilical region a rounded

cake-like tumor with irregular surface, four inches in diameter, and apparently covered over by intestine, was felt. On the right side of the tumor and in the right iliac fossa, tenderness was marked. Diagnosis: tubercular peritonitis.

July 3d.—The patient was evidently weaker. Moderate fever was constant with evening exacerbations. The abdomen was more distended, peritoneal crepitus could be felt; night sweats, occasional vomiting, and abdominal pain were noted. The scanty sputum was examined for bacilli with a negative result.

July 14th.—Several days before this date it was noticed that the skin about the navel was getting red and cedematous. On this date a small perforation took place through which with each inspiration was emitted offensive gas, on deep inspiration offensive greenish fluid; during the act of vomiting this fluid was ejected with force.

July 18th.—The fistula gradually enlarged, and the patient was transferred to surgical side.

July 19th, and again on the 22d, dejections of normal consistency passed the rectum, the only discharges of any kind through that outlet between the appearance of the perforation and death, which took place July 28th, from exhaustion.

Autopsy.—The right pleural cavity was obliterated by old adhesions, a few of which were also found on the left side. The apex of the right lung was thickened, shrivelled, and dense; on section, numerous small gray tubercles, and some pigmented fibrous tissue were seen. Throughout both lungs there were occasional cheesy patches, a half-inch or more in diameter, some of them partially softened, surrounded by deeply injected borders containing miliary tubercles.

A fistulous opening through the umbilicus contained a drainage-tube entering the peritoneal cavity partially obliterated by old adhesions. This encysted cavity extended upward beneath the right lobe of the liver, and downward on the right to the pelvis, containing masses of necrotic fat tissue (omentum), and several ounces of offensive fluid; it communicated with the rectum above the internal sphincter by an opening in the anterior wall half an inch in diameter. The intestines contained tubercular nodules and ulcerations, chiefly in Peyer's patches.

The pathological diagnosis then was

chronic pulmonary tuberculosis, acute bronchitis, tubercular peribronchitis, chronic tubercular peritonitis and enteritis, umbilical fistula, perforating ulcer of the rectum.—*Bost. Med. and Surg. Jour.*, May 26, 1887.

Sutton (B.) on Rickets in Animals.

—The bones preformed in membrane were much thickened, and the diploë absent. The reverse of this process obtained in the cartilage-formed bones, they being very much thinned. Paraplegia developed in carnivorous rickets as the result of the epiphyseal plates of the vertebræ becoming greatly overgrown. The tentorium cerebelli was enormously ossified; instead of being a thin plate of bone, it had become a veritable exostosis. Reference was made to the case of a cub which at two months of age became paraplegic. The tentorium was greatly ossified, and there was great dilatation of the cerebral ventricles as occurred in the brain in hydrocephalus, and due to interference with the circulation of cerebro-spinal fluid. Paraplegia was the first sign; then the head was drawn to one side and convulsions set in. Afterwards oscillation of the eyeballs and rhythmic movements in the head were observed. These symptoms were parallel to those described by Hilton, Wilks, and Moxon in cases of hydrocephalus in children.—*Lancet*, May 21, 1887.

Van Bibber (W. C.) on an Erosion of the Mucous Membrane into a Varicose Vein near the Cardia with Hæmatemesis.—The patient was a comedian of sixty-five, weighing one hundred and sixty pounds. He had been a high liver, and given to performing feats requiring considerable expenditure of strength. During two years he had six violent hemorrhages from the stomach, most of them following a muscular effort, and the last one proving fatal.

The autopsy disclosed marked cirrhosis of the liver, a spleen thrice its normal size, and a perforation of the mucous membrane of the stomach near the cardiac end, leading directly into a large varicose vein.—*Maryland Med. Jour.*, Jan. 15, 1887.

Foot (A. W.) on the Common Tape-Worm.—Up to a very recent period—if it be not so at present—it was considered that the common tape-worm of Great Britain and Ireland was the *Tænia solium*, or pork tape-worm. This opinion is now very much altered, and the *T. solium* ap-

pears to be less frequently met with than *Tænia saginata* (*mediocanellata*).

To determine the species (*solium* or *saginata*), one or more of the most mature proglottides is snipped off the chain and immersed in acetic acid on a watch-glass. After having been treated thus for an hour one of the links, pressed between two glass slips, is held up between the eye and the light. The arrangement of the uterus and its appendages can be clearly seen with the naked eye, and better still by the use of a lens or magnifying glass. The median stem of the uterus appears as a wide longitudinal canal running along the middle of the joint. At right angles to this main stem there about on either side from twenty to thirty branches, succeeding each other at short distances and passing outwards, transversely to the long axis of the link, towards the lateral margin of the segment, close to which they all end blindly. In *Tænia solium* the median stem is shorter, corresponding with the shorter joint; the lateral branches are further separate and fewer in number, amounting hardly ever to more than nine on either side, and usually only to seven.

In diagnosing the presence of *T. saginata* it is also an assistance to bear in mind the tendency its mature segments show to leave their host spontaneously, an act which is very rarely observed in the case of *T. solium*. This spontaneous emigration of the proglottides causes a troublesome and disagreeable tickling. In warm, damp environments they can retain their motion and life even for days. The individual links may creep about the legs till the continued lowering of temperature brings them to a standstill. In the warmth of the bed they often creep over the whole body, especially if the skin be somewhat damp. This mobility is the result of the considerable muscular development prevalent throughout every link of the chain, which contributes not a little to the thick and fat character of the *T. saginata*, and explains how the worm can work its way back into the intestine even when it has been so far expelled that a long piece of it hangs out of the rectum or anus. It is quite conceivable that the powerful contractions of *T. saginata* may be related to the sensations of heaving up and down which some who harbor these worms state they experience in the intestines.—*Dublin Jour. Med. Sci.*, May 2, 1887.

Carrico (L. C.)—Broncho-Pneumonia Versus Nematoda.—The little patient, æt. three, was just recovering from an attack of whooping-cough, and on the previous days complained of chilliness, which was soon followed by fever and much difficulty in breathing.

Upon seeing the little one I observed the breathing to be very rapid, superficial, and labored; respiration 52, pulse 140, temperature 103.4°, and cyanosis extending over the entire face. On auscultation *râles* were found abundant over the chest, but the examination was not satisfactory, owing to the excessive dyspnoea and fretfulness of the child.

From the previous history of whooping-cough, and the initial symptoms of the attack, as well as the sensible signs, broncho-pneumonia was promptly diagnosed, and an emetic exhibited with the most happy results.

The vomiting brought up a full-grown worm, nine inches long, and from that time on recovery took place uninterruptedly.—*Maryland Med. Jour.*, April, 30, 1887.

Lacombe on Subpectoral Abscess Evacuated by the Bronchi.—The author narrates the case of a woman of thirty-eight, in whom an abscess, located under the right breast, rather suddenly diminished in volume with a simultaneous coughing up of large amounts of pus from the lungs. An opening made into the abscess gave vent to air, and direct connection was traced between the surface and the bronchi. Complete recovery supervened. — *Paris Médicale*, Dec. 4, 1886.

Stedman (C. E.) on a Case of Diffused Gangrene of the Right Lung, Following Pyorrhœa Alveolaris.—The patient was thirty-one years old, and had been married four years. Her father died of pneumonia. A paternal grandfather died of cancer. She had never been a robust woman. She was specially subject to chills, which were called malarial, but which were probably due to the condition of her gums, which had been diseased for eight years or more.

On the day before the operation she had one of her chills, but it did not confine her to her chamber. Her teeth were extracted on the 8th; a slight cough and fever developed on the 9th. The gums healed in quickly, and such fetor was noticed as would be expected from the suppurating

surface, and was relieved by a myrrh lotion. For a day or two she seemed to be recovering from the operation, as on the 10th the temperature was 98°; but on the 13th of October pneumonia was suspected, because the temperature shot up to 103.4° (the highest point it reached). The pulse was as high as 120 on one day only. There followed cough; scanty expectoration of not very viscid sputa, at rare intervals rusty. During the first few days there was some delirium. The physical signs at first were negative; to the last, the front of the chest was clear, and the heart-sounds normal. Evidences of consolidation were heard in the middle of the right back, and extended downwards and upwards, till little or no free respiration could be heard. There was little or no pain. The sputa, never abundant, grew more and more fetid. After one or two remissions, which, for a day or two at a time, gave hope, she died, in full consciousness, at midnight, on the 31st of October, on the nineteenth day of the disease. The autopsy was made by Dr. Fitz on the 2d of November, and he has kindly sent me his notes.

Right lung adherent throughout by fresh adhesions, except at the base, in front and behind, where circumscribed cavities were found. In each were about four ounces of foul-smelling, opaque, greenish-yellow fluid; these cavities communicated with the interior of the lung through sloughing tissue. The right upper lobe showed nothing abnormal; the lower lobe moderately retracted. A few cavities as large as English walnuts were present, with sloughing walls and offensive contents. In several instances the beginning cavity-formation followed the course of the bronchial distribution, dilated bronchi being thus suggested. There was but little solidification of the lung-tissue between the gangrenous centres. The spleen was slightly enlarged and soft; the kidneys and liver presented the appearance of parenchymatous degeneration. Diagnosis: Gangrenous bronchopneumonia; putrid empyema. — *Boston Med. and Surg. Jour.*, May 12, 1887.

Hirtz (E.) on Angina Pectoris.—The author reports a case of acute aortitis with attacks of angina pectoris, which terminated fatally. The autopsy showed the presence of acute primary aortitis without atheroma. The fact that in this case the coronary arteries were healthy and in no

way occluded, seems to prove to the author's mind that angina pectoris need not necessarily depend on disease of those arteries.—*Four. de Méd. et de Chir. prat.*, May, 1887.

[The fact that the coronary arteries appear healthy after death seems to me to prove by no means that they were not *functionally* deranged during life.—ED.]

Suicide with a Darning-Needle.—

On the 15th inst., Dr. Danford Thomas held an inquest at Clerkenwell on the body of Charles Nutter, aged seventy-seven, who was found dead in bed with a common darning-needle fixed in the epigastrium. Through the eye of the needle a cross-bar of tin had been threaded, and this had been fixed firmly in position by binding with worsted. The object of the deceased man (the jury returned a verdict of "suicide whilst of unsound mind") was, no doubt, to make an instrument wherewith he could effectually encompass his end. Over the epigastrium and lower part of the chest were nine punctures: the one already mentioned as containing the needle, which had caused a superficial laceration of the liver; another had passed through the fourth right intercostal space and had penetrated the right ventricle and entered one of the posterior set of muscoli papillares. Through the small puncture blood to the amount of nearly a pint had escaped into the pericardium, where it was found in part liquid and in part firmly coagulated. The remaining punctures had only extended into the abdomino-thoracic walls. There are several points of interest suggested for examination. In the first place, as regards the suicidal or homicidal origin of the wounds. The fact of a needle being used to inflict a mortal injury on an exposed part and being left *in situ* was of itself practically sufficient to negative the theory of murder; but there was further circumstantial evidence tending to show that deceased committed suicide. The heart was greatly hypertrophied and dilated. This is important as furnishing presumptive evidence that the epigastric pulsation led the deceased to make the punctures where they were found, instead of, as is usual, immediately over the cardiac region. The case shows that penetration of the cardiac cavities by means of a small instrument is not necessarily suddenly fatal, for it is clear that deceased must have lived for a considerable time—

probably an hour or more—after the fatal puncture was made, considering the size of the opening into the ventricle and the large quantity of blood found in the pericardium. No injury of the coronary vein or of either coronary artery could be detected.—*Lancet*, Jan. 29, 1887.

McDonnell (R. M.) on Congenital Absence of the Petrous Portion of the Temporal Bone.—

The specimen was the skull of an idiot which had been dissected at McGill College. There was on both sides deficient development of the petrous portion of the temporal bone. The base of the skull, as seen from within, was flat, the petrous bone not forming the normal ridge between the middle and posterior fossæ. The organs of hearing had never reached development, there being in reality but a rudimentary tympanic cavity. The foramina through which the various nerves passed were small. No previous history of the case had been obtained. The subject presented several other abnormalities: 1. The right common carotid divided into its external and internal division opposite the lower border of the thyroid cartilage. 2. The left common carotid did not divide at all, but was continued upwards as the internal carotid; the superior thyroid and lingual arteries were given off this common trunk, and the facial from the lingual. 3. The hypoglossal nerve was given off from the pneumogastric. 4. There was deficient development of the teeth. The bicuspidis were represented by small round pegs. The molars were ill-formed, small, and rounded like milk-teeth.—*Canad. Pract.*, March, 1887.

Kisch on the Relation of the Sex of Children to the Age of Parents.—

When the husband is at least ten years older than the wife, and when at the same time the wife is within the age of highest reproductive power (twenty to twenty-five), there will be a very distinct excess of boys born over girls. This excess will be marked, but less distinct, when the husband is at least ten years older than his wife, and she is over twenty-six. When the husband is older than the wife, and she has not attained the age of highest reproductive power, the female births will be in excess. This excess of girls born over boys is most marked when husband and wife are of the same age. Yet when the wife is the elder there is a distinct excess of male births.

Dr. Kisch admits that both his own and Hofacker's statistics are not extensive enough to warrant very decided scientific conclusions. His interesting paper is published in the *Centralblatt für Gynäkologie*, January 22, 1887.—*Br. Med. Four.*, Feb. 12, 1887.

Fowler (G. B.) on Melena Neonatorum.—Frank K., born March 24, 1886. Mother, Ipara. Family history: father and mother healthy, but when seventeen years old "she spit up a large quantity of blood." She first menstruated when eighteen years of age. Pregnancy normal; labor normal; first stage, thirteen hours; second stage, one hour. Child well nourished; weight, six pounds eleven ounces; nursed well, and nothing unfavorable was noticed until thirty-six hours after birth, when the infant refused to nurse; one hour afterward it commenced vomiting blood, the vomiting being followed by profuse hemorrhage from the bowels, estimated at one half ounce, followed during the afternoon by three other hemorrhages; the second about the same quantity of blood as at first; the third and fourth about two drachms; vomiting continued, and there were slight hemorrhages during the nights of 26th and 27th. The vomiting of blood continued until 7 A.M. 27th; at 2 P.M. the infant commenced nursing, and continued to improve, and finally recovered.—*Am. Four. Obst.*, etc., Feb., 1887.

Detection of Blood-Spots on Iron.

—Dr. Dannenberg contributes some valuable data on detection of blood-spots on iron. Blood is easily proven on ordinary surfaces by means of the crystals of haemine, but when blood-spots on rusty iron are to be examined, their detection is not so simple a matter, as the iron rust seems to form a combination with it. Dr. Dannenberg, however, states that if a few drops of a roper-cent. solution of caustic potash be placed on the spot, and thus loosened, the rust scraped off and treated with ammonium sulphide and water, and then handled according to the usual method, elegant extended rhombic crystals will be formed. He considers these as conclusive proof, and names them "haemidin" crystals.—*Four. Am. Med. Ass'n*, March 5, 1887.

Velamentous Insertion of the Umbilical Cord.—In this form the cord, instead of going to its attachment at the centre of the placenta, breaks up on the mem-

branes, and the vessels straggle onwards between the membranes to the placental margin. It is evident that such a disposition of the vessels exposes them to grave risk at or before the rupture of the membranes. If a vessel of any size be involved in the tear, copious and even fatal hemorrhage will at once supervene, and the foetus promptly becomes exsanguineous.—*Med. Press*, March 23, 1887.

Diseases and Injuries of the Spine.

—Dr. Noble Smith (*Brit. Med. Four.*, Dec. 11, 1886) relates numerous cases of spinal caries in which the symptoms were obscure. Cases which had existed three years and more, the deformity angular and steadily increasing to a very severe degree, with no pain anywhere at any time. Cases in which the pain was felt chiefly or entirely in the back, and was severe and nearly constant. The spine of the late Dr. Buckland, who died at the age of fifty-two, showed extensive carious disease in the five upper cervical and a portion of the occipital, but "no other symptoms manifested themselves during life but those attributed to melancholia." Another case in which the atlas and axis were almost completely destroyed, showed, during life, no pain on rotating, or nodding or pressing the head; no difficulty in raising it; none of the characteristic fear in moving it; no thickening over the bones; no tenderness or swelling behind the pharynx; in fact, until the final illness, nothing but wry-neck. And cases have been mistaken for croup and hydrocephalus. The absence of deformity, although long known to be compatible with a severe degree of caries, is often in the present day thought to be a proof of the absence of this disease.

Dr. George W. Ryan (*Med. Surg. Report.*, Dec. 11, 1886) expresses surprise that many excellent observers should regard the knuckle as the first symptom of vertebral caries. He considers as of chief importance the following: a family history of tuberculosis; a tardy convalescence from infantile diseases; restless nights, moaning and disturbed sleep, a tired feeling, or a continued desire for support; walking with care, it screams with pain when it falls; it holds its back rigid and does not stoop, or stoops with great care; there is pain in the back when a jar is sustained; and the gait is pathognomonic. When the clothing is removed and the patient caused

to lie on its face, if the spine is found to be rigid, the diagnosis is unmistakable.

Dr. Lewis A. Sayre (*Med. Register*, May 7, 1887) suggests that, after stripping the patient, you lay him across your lap, face downward, with the arms over one thigh and the legs over the other, then gradually separate your thighs. When this is done, the first thing you will probably notice, if spondylitis be present, will be that the child takes a long breath, a sigh of relief, in contrast to the short, grunting respiration so constantly seen.

Dr. Charles F. Spangler (*Med. Bulletin*, March, 1887) recommends to those desiring to apply a plaster-of-Paris jacket, who have not the usual suspension apparatus, to suspend the patient by having one assistant support the patient with the hands under the arms, while the other steadies the head.

Dr. Richard Davy (*Brit. Med. Four.*, April, 1887) places the patient on his stomach in a hammock.

Dr. H. L. Taylor (*Med. Record*, Jan. 8, 1887) says: "It is fortunate that the protective means employed to arrest the morbid process tends not only to prevent increase of deformity by checking the disintegration in the acute stages of the disease, and the yielding and compression of the new tissues which inevitably occur where protection is too soon discontinued, but that it can also be so used as to cause positive amelioration of the deformity in many cases, and absolute recession in a few. It can be made to develop whatever capacity of straightening there is in the compromised column. The average ultimate result in Dr. C. Fayette Taylor's private practice, using his antero-posterior leverage supporting and protecting apparatus thoroughly and for a sufficient length of time, has been, under favoring conditions of attendance and home attention, the definitive arrest of the deformity at or near the point it had reached when such protection was furnished. There remain, however, a small class of cases where the deformity increases in spite of good care; and a larger class where, owing to too infrequent visits, which preclude those progressive and delicate modifications of detail which the varying indications of the disease demand, and which are so essential to proper support and the best results, or to the lack of patient, intelligent, and painstaking home attention, there will be gradual,

and, it may be, extensive increase of deformity."

At the meeting of the New York Surgical Society, April 17, 1887 (*N. Y. Med. Four.*, May 14, 1884), Dr. A. G. Gerster presented a patient who had recovered from a fracture of the fifth cervical vertebra. The patient was thirteen years old, and the injury was sustained by diving at the seashore into shallow water. The boy was stunned and there was paralysis of the left upper and lower extremities, and of the bladder and rectum; also of the right upper extremity (with the exception of the shoulder-muscles), with paresis of the corresponding leg. The spinous process of the fifth cervical vertebra was depressed and gave marked crepitation on stretching the patient's neck and then letting go of it. Treatment was by weight extension with Glisson's apparatus.

In the same journal of Nov. 27, 1886, there is mention of three cases reported by Dr. R. B. Bontecou. Two of the patients died soon after the injury. The other patient had paralysis, but lived twenty years and became able to resume his occupation, that of a painter. He was treated by continuous extension for several weeks. At the autopsy the fourth, fifth, sixth, and seventh cervical vertebræ were found fused together.

Dr. G. H. Haines (*Brit. Med. Four.*, Feb. 5, 1887) reports a case of fracture of the upper cervical spine with recovery. The patient, a lady, fell twenty steps of a staircase: and in addition to numerous contusions and a Colles' fracture of the left forearm, there was complaint of intense pain at the back of the neck, radiating over the region supplied by the sub-occipital nerve. No deformity could be detected; but the slightest movement of the head in any direction so intensified the pain, that any attempt to ascertain the existence of crepitus was rendered impossible, as also by the rigid condition of the whole of the muscles of the cervical region. After ten days' rest, the pain having in some measure subsided, the patient was allowed to get up, when on some involuntary movement a sudden and audible click occurred. After this distinct crepitus was produced by fully extending the head and at the same time making lateral pressure on the posterior segment of the atlas. Treatment was by sand-bags and an india-rubber air collar.

Dr. D. Schoolfield (*Cincinnati Lancet-Clinic*, Dec. 4, 1886) reports a case of dislocation of cervical vertebræ. The patient was a boy æt. thirteen years, and he was injured by a wheel of a cart loaded with dirt passing over his neck. In addition to the neck injury the inferior maxilla was fractured in two places. He complained greatly of pains in his arms and a feeling of numbness; there was inability to grasp any thing tightly; sensation slightly diminished, and efforts of coördination impaired. There was great swelling about the neck, but no prominence, depression, or perceptible curvature. Paralysis became more marked; the respiratory muscles of the chest became involved; the breathing more irregular; the pulse slower and occasionally intermittent; the bowels constipated, and retention of the urine. He died on the fifty-third day from the time of the injury. The autopsy showed complete dislocation of the third and fourth cervical vertebræ. The lumen of the canal was not greatly diminished. The membranes of the cord were but slightly inflamed, the cord at the seat of injury somewhat congested, but showed no evidence of softening except at the junction of the fourth and fifth cervical vertebræ.

Dr. Carl Lauenstein, of Hamburg, has successfully resected two vertebral arches for the paralysis due to compression of the spinal cord caused by fracture of the spine. Attempt was first made to obtain relief by suspension and the application of the plaster jacket, but this failed.

Dr. W. T. Councilman (*Med. and Surg. Reporter*, April 9, 1887) reports a case of sarcoma substituting the sixth cervical vertebra. The patient was sixty-two years old, and the exciting cause a fall, striking the head and neck against a railing. There was intense pain in the occipital region, and nausea. He was able to return to work after some three months, but stiffness of the neck and some nausea remained. Dr. Councilman first saw the patient some six months after the injury. The head projected forward, and there was slight rigidity of the scaleni on the left side simulating a spastic condition of these muscles, very sensitive to pressure. He was unable to move his head toward the left or bend it back. There was no disparity in his pupils or paralysis about his tongue. His grip was diminished most markedly on the left side, and great increase of

patellar reflex on the same. He was utterly unable to stand alone with his eyes closed, and had the uncertain gait of an ataxic. Soon he began to complain of a constriction about the abdomen and tingling in his feet and legs—the paralysis being much more marked at first in the upper extremity, and later absolute in the lower extremity, bladder, and, last of all, in the rectum. Thus he lived on for about five months. The autopsy showed that the entire sixth vertebra, with the exception of articular facets and some small pieces of the arch and spine, was missing. The body of the seventh cervical vertebra was eroded, spongy, and reduced to half-normal size. The body of the fifth also eroded, but not so much. There were also eroded surfaces on the arches and spines of the fifth and seventh, on the left side. Lying along the seventh vertebra, on the left side, filling up the loss of substance in its body, and extending up alongside to the fifth vertebra, was an irregular, firm tumor mass, about the size of a small walnut. Microscopic examination of this showed it to be a round-cell sarcoma of the large-celled variety.

Dr. Frederick J. Smith (*Lond. Lancet*, May 7, 1887) records a case of malignant disease of the right lung and posterior mediastinum, which, apparently beginning in the neighborhood of the right bronchus, had extended in all directions during its three years' course, and softened and infiltrated the bodies of two or three of the upper dorsal vertebræ, causing complete paraplegia, by having compressed the spinal cord to such an extent as to have almost obliterated it opposite the fourth dorsal vertebra, with softening above and below this point for some distance. The case is of interest because of the difficulty of diagnosis before the myelitis developed.

Dr. A. B. Judson (*N. Y. Med. Four.*, March 26, 1887) reports a very interesting case, in a child æt. four years and eight months, showing the difficulty of differentiating in diagnosis between caries and malignant disease when occurring in children.

Dr. R. W. Amidon (*N. Y. Med. Four.*, Feb. 26, 1887) gives a detailed account of three cases occurring in his practice and an analysis of twenty-one other recorded cases. The conclusions which he draws from a study of these may be found in the May, 1887, number of the ANALECTIC.

JOHN RIDLON, M.D.

DISEASES OF THE EYE
AND EAR.

Jonassen on Color-Blindness.—In the course of four years he has examined 5,000 employés of the Victorian Railways of Australia. The percentage of color-blindness was 3; but a considerable percentage besides were what he called color-blunt—that is, were slow to name what they really saw. He never decided on doubtful cases at one examination, giving them a second after they had time to familiarize themselves with the colors. He employed the usual system of worsteds described by Prof. Holmgren, of Upsala. Besides describing a class of persons whom he well names color-blunt, he makes the following statement of the mistakes that the actually color-blind make, according to the part of the spectrum they are blind to. The general statement by others has been that the “green-blind,” in selecting or matching the red-purple test skein, will put greens with it, while the “red-blind” will put blue skeins with the same test skein.

Dr. Jonassen has noticed that instead of this both “red-blind” and “green-blind” mistake red-purple for blue—that is, select the blue to put with the test skein of red-purple. It is also incidentally brought out in the discussion on the paper of Dr. J. that the examinations for color-blind are very thoroughly applied for the railway and marine service of the colony; and that the percentage of color-blunt equals that of color-blind, viz., 3.—*Austral. Med. Four.*, Feb. 15, 1887. A. T. M.

Rampoldi (R.)—A New Cause of Mydriasis.—The attention of ophthalmologists has been drawn twice before by the Dr. to one of the less-known causes of sympathetic mydriasis.

In certain persons suffering from chronic broncho-alveolar inflammation, the phenomena of a transitory mydriasis is presented at intervals, sometimes bilateral, more frequently unilateral. It has been noted at the same time that this mydriasis happened especially when the patient had passed a wakeful night tormented by a cough. And when the mydriasis was unilateral, it has also been proved that the patient complained of pain in the shoulder, and more particularly the subclavicular and subspinal fossæ of the same side. The theory advanced is that the irritation from

coughing passes through the cervical sympathetic to the radiating muscular fibres of the iris; and gives notes of three new cases in which the above facts are shown.—*Recueil d'Ophthalmol.*, Paris, March, 1887. A. T. M.

Theobald (S). A. Decided Improvement in the Construction of Lachrymal Probes.—The doctor has had probes for the treatment of the lachrymal canal made of aluminium. As the metal is not capable of being soldered, the shields have to be fastened by other means. The advantages of the aluminium are: lightness, sp. gr. being 2.56, that of silver pure being 10.4; smoothness, making them much easier of introduction and removal. The patients readily detect the difference in this, as well as the former point.

The appearance of the aluminium probes closely resembles the silver. The former are a bluish-white as contrasted with the yellow-white of the latter. The lightness makes it possible to manœuvre the larger sizes much more skilfully. Yet the author believes that this advantage of aluminium over silver does not hold for the sizes smaller than No. 7. He prefers coin silver for the smaller probes. He also adds a word in favor of using larger probes generally, admitting that in so doing he puts himself among the minority. He thinks that relapses are prevented by their use, and the original treatment shortened. Two thirds of cases among adults require No. 16. He has before reported treatment of thirty-four cases. Thirteen only required a smaller probe than 16, and seven of these took No. 15, and only one of the remaining six was an adult.—*Am. Four. Opthal.*, St. Louis, March, 1887. A. T. M.

Jeaffreson (C.S.) on a Curious Lachrymal Case.—On Saturday, Jan. 29th, a young man came to my clinic. The whole of the right side of his face was considerably swollen, puffy, and covered with scabs in places. About half an inch below the lower lid in the angle formed by the cheek and the nose, but far removed from the lachrymal sac, these crusts became unusually thick, and projecting from their centre was visible the upper extremity of a hollow silver lachrymal style. Struck by its unusual position, I began to seek for the distal extremity. This was found in the mouth between the gums and cheek, just above the socket of the right canine tooth. It had not perforated the mucous membrane,

owing to the discharge produced by its irritation having found exit through the cheek, but it could easily have been pushed through had it been of sufficient length. Any movement communicated to the cheek moved the whole tube *in situ*, and it had obviously never been in the proximity of the lachrymal apparatus or nasal duct. The way the operation must have been performed was no doubt as follows: The supposed position of the lachrymal sac having been determined, an incision through the skin was made over it. The subcutaneous structures having been reached, the style was pushed downwards, passing in front of the superior maxilla below the whole thickness of the cheek, and was there left. The tube had been in its present position for fourteen months, and it is needless to say the slight lachrymal obstruction which it was intended to have cured had derived no benefit.—*Lancet*, Feb. 12, 1887.

Carter (B.). Case of Swollen Optic Disc, in Which the Sheath of the Optic Nerve was Incised behind the Eyeball.—A young woman sought advice on November 18th last, on account of impaired sight of her left eye and headache, these symptoms being of ten days' duration. The left optic disc was much swollen, and the eye was blind over the temporal half of its field of vision. The patient was admitted into the National Hospital for Epilepsy, Queen Squire, under Dr. Hughlings Jackson and himself. Iodide of sodium and mercurial inunction were prescribed. She speedily became mercurialized, but her condition did not improve. Hemorrhages and patches of exudation appeared in the swelling. On December 28th, Mr. Carter divided the external rectus muscle, rotated the eyeball inwards, exposed and opened the sheath of the optic nerve, and gave exit to the contained fluid. The patient was at once relieved of headache, which did not return for a month. The swelling gradually diminished, and the field of vision was restored. Mr. Carter pointed out that this operation could be accomplished with certainty and without danger, and advised its employment in every case of swelling of the optic disc.—*Br. Med. Jour.*, March 26, 1887.

Bacon (G.) on Sea-Bathing a Cause of Ear Disease.—The manner in which the ear is affected is either the direct im-

pact of the water against the drum, as a wave strikes the side of the head and face, and in diving, or it reaches the middle ear through the open mouth or nostrils. This is a very frequent way for the water to reach the ear. Besides the mechanical effect, the ear may resent the coldness of the water, when this is sufficient to seriously shock the system, or when the system has been exposed to its influence too long. Dr. Burnett is quoted as saying, that no mammal but man voluntarily goes under water, without means provided for preventing water running into the ears, and it is a well known fact that hunting dogs taught to dive become deaf. Five cases are given. In 3 the aural symptoms appeared 24 hours afterwards; in 2, within an hour.

In 2 cases clots of blood upon the membrane showed evidence of direct violence done.—*Med. News*, Phila., Jan. 29, 1887.

A. T. M.

SURGERY.

On the Treatment of Hernia.—Dr. W. B. De Garmo, in the *Medical Record* for January 8, 1887, published an interesting paper, giving a brief review of the history of the subcutaneous treatment of hernia up to 1877, in which year Heaton¹ published his method, and describing some important points to be observed, in the carrying out of Heaton's operation.

Subcutaneous operations done by Velpeau, Pancoast, and others, consisted in the injection *into* the hernial sac, of an irritating fluid, while Heaton's method was to deposit the fluid *outside* the hernial sac, to fortify the fibrous and connecting tissue surrounding the canal, through the astringent, and mildly irritating effect of the white oak-bark.

Too much was expected of this operation by those at first employing it, because it was not taken into consideration that patients operated on by Heaton, who had used the method for years, and who had the patients under control in a private hospital, ought to respond better to treatment than those under the care of the general operator.

¹ "The Cure of Rupture Reducible and Irreducible; also of Varicocele and Hydrocele, by New Methods." By George Heaton, M.D. Edited by Dr. Henry Davenport. 1877.

One frequent error in the performance of the operation has been in making the puncture through the scrotal tissues instead of directly through the integument over the external ring. If such a puncture is made, swelling of the scrotum and testicle is apt to occur, some of the fluid probably following the needle as it is withdrawn. Then, too, if the hernial sac is of large size and adherent, the fluid is apt to be deposited in it rather than outside the sac.

The author at the time of operating introduces his finger into the external abdominal ring, and crowds the spermatic cord and sac outward, toward the external pillar, and introduces the needle between this finger and the internal pillar of the ring, while Heaton did the reverse. Dr. De Garmo has never had any abscess follow an injection, and as others have had such accidents, he attributes his results to the fact that immediately after the withdrawal of the needle he makes firm and continuous pressure for some minutes, to prevent the fluid following the track of the needle, and to cause it to be diffused among the tissues inside the ring.

The after-treatment is of the utmost importance. The patient should remain in bed from five days to a week, with a Heaton bandage or a light truss on, and on going about should continue to wear a truss for some weeks.

Cases that can be fully controlled by means of a truss may be successfully treated by the injection of from five to ten drops of Heaton's fluid, at intervals of about two weeks, repeated, four or five times without confining the patient at all.

The writer's conclusions from seven years' experience with Heaton's method, during which time he had employed it in over a hundred cases, were: 1. That it was free from danger. 2. That over forty-five per cent. of all cases could be cured by it, and in select cases seventy-five per cent. 3. That many extreme cases uncontrollable by means of a truss could be brought under control by the operation. 4. That it was followed by improvement in almost every instance. 5. That children not cured by mechanical means could in almost every instance be cured by Heaton's operation.

In the *Medical Record* for March 5, 1887, Dr. R. F. Weir discusses Heaton's opera-

tion, and describes several cases treated by the radical (open) operation.

In performing the latter, he thinks it best to leave the hernia in the sac at the time of the operation, as it renders the latter easier.

In coming down on the hernia, more certainty will be attained and less delay produced, by deepening the incisions, after going first through the skin and fat above the external ring until this latter is definitely made out and exposed, when the hernial sac can be more quickly and easily reached by tearing through the connective tissue at this point with two forceps, and its neck more readily encircled by the finger than by any other way. By stripping it now downward, it can often be peeled throughout from its attachments with great facility, and the more rapidly the sac is reached and lifted out of its bed, the less likely is suppuration to occur. In this way, also, is the detachment of it from the spermatic cord best accomplished.

Dr. Weir favors the excision of the omental part of a hernia, believing that its abnormal length tends to produce a relapse, and if this is done the stump must be very firmly and carefully ligated to prevent hemorrhage.

Weir had performed MacEwen's operation six times, and describes it. In this operation the sac is exposed and its contents, the abdominal aspect of the internal ring, and the position of the epigastric artery ascertained.

The sac is then freed from its attachments, and a finger passed along it through the internal ring, where the parietal peritoneum is stripped off for half an inch around this ring.

A catgut suture is then fastened at the distal end of the sac, and from that point the other end of the suture is carried on a needle in a proximal direction several times to and fro through the sac, and finally is made to traverse the canal and to penetrate the anterior abdominal wall about an inch above the internal ring, the wound in the skin being pulled upward, so as to allow the point of the needle to project through the abdominal muscle without penetrating the skin. The thread is pulled through the abdominal wall, and when traction is made upon it, the sac wrinkling upon itself is thrown into a series of folds, its distal extremity being

drawn farthest backward and upward. An assistant maintains traction upon the stitch until the introduction of the sutures into the inguinal canal, and when this is completed the end of the stitch is secured by introducing its free extremity several times through the superficial layers of the external oblique muscle. A pad of peritoneum is thus placed upon the abdominal side of the internal opening. A finger is then passed into the internal ring to define its borders and guard the epigastric artery. A suture is then carried on a hernia-needle on a Hagadon needle through the conjoined tendon from without inward, and then from within outward, leaving a loop on its peritoneal side. The two ends of the suture are then carried across the ring and canal, and the lower one made to pass through Poupart's ligament and the aponeurotic structures of the transversalis, internal and external oblique muscles, while the upper one is brought through these three muscles only, at points corresponding in height to the place of exit of the suture from the conjoined tendon. The free ends are secured by a double reef-knot. MacEwen advises that a drainage tube be inserted and the wound closed. Weir prefers to allow the upper part of the wound to heal by granulation, expecting to get thus firmer tissue.

In congenital hernia the sac is freed from the canal, opened and divided transversely in two, preserving the cord. The lower part is formed into the *tunica vaginalis*, the upper part is pulled down and split longitudinally for the cord to escape, and is closed by sutures, and treated as the sac of acquired hernia.

Dr. Weir's conclusions are that small reducible easily controlled inguinal hernias can with safety be treated with Heaton's injection, and with a reasonable prospect of success; that in similar hernias in children Heaton's injection is a particularly successful procedure; that in unmanageable, painful, or irreducible hernias, demanding surgical interference, and sometimes those in which Heaton's has failed, the radical operation should be resorted to, with the sac tucked up, or tied off, as the surgeon may determine, but with a high and complete suturing of the canal.

In the May number of the *St. Louis Medical and Surgical Journal*, Dr. A. C. Bernays, in a preliminary communication,

describes a new method for the relief of strangulated hernia.

"The operation consists simply in the subcutaneous tenotomy of the crural arch; in other words, in cutting through Poupart's ligament. The incision is to be made about the middle of the ligament in an upward direction, and need not cut any thing but the ligament itself. The method which I recommend is as follows: A small incision one eighth of an inch in length is made through the skin only, in a vertical direction, exactly in the inguinal fold. Next, a probe-pointed knife is pushed through the subcutaneous fatty tissues under Poupart's ligament, which is found tense, and by pressing the ligament against the edge of the knife from without with the left hand, while the right hand holds the tenotome, the ligament must be cut. The knife is withdrawn as soon as the resisting ligament is cut. If, after the probe-pointed knife is introduced, Poupart's ligament is found relaxed, it should be immediately withdrawn; for, in all probability, we have to deal with one of those (fortunately exceptional) cases in which the strangulation is caused by the sac itself, and its cause is not to be sought for in the inguinal or femoral canal.

After the ligament is cut the hernia will almost immediately slip back, if the patient is not too deeply anesthetized, or it can be returned to the abdominal cavity with the greatest ease by manipulation.

GEO. B. PHELPS, M.D.

Bernays (A. C.) on Fibroid Tumor of Abdominal Parietes of Thirty-five Years' Duration—Malignant Degeneration after an Injury—Successful Removal.—The patient was a German farmer aged fifty-nine. Thirty-five years before the operation there was a small movable lump situated beneath the skin near the umbilicus.

Nine years ago it began to increase in size and became as large as a hickory nut. In September, 1886, patient fell and the tumor was injured by a sharp piece of steel wounding it. The wound healed but the tumor began to rapidly increase in size, and finally ulcerated.

It was removed by an elliptical incision transverse to the linea alba, this being the direction of its longest diameter, and was found attached to the posterior sheath of the rectus muscle. The patient made a good recovery.

Microscopic examination showed the tumor to consist of two parts: the original growth was a fibroma, the latter one a sarcoma.

The abdominal parietes are rarely the seat of neoplasms. Fibroids are the most common of all tumors; next in frequency we find sarcomata.

These tumors occur in women eight to ten times more frequently than men, and attain in the former a larger size, while in men they are more often of a malignant type.

The prognosis of fibroid tumors of the abdominal walls must be considered a bad one in the long run. Early removal is indicated. Langenbeck, in 1850, first performed the operation. Up to 1880 but five cases of fibroid tumors in the abdominal parietes of the male have been reported.—*Med. Brief*, May, 1887. [G. B. P.]

Parker (R. W.) and Robinson (H. B.) on a Case of Inherited Congenital Deformity of the Feet.—The patient was a child three and one half years old. The two inner toes were coalesced into a single great toe, and the three outer toes were similarly united into a little toe; the coalescence extended in part into the metatarsal bones, and there was a wide and deep cleft between.

An operation was performed which consisted in removing the skin from the contiguous parts of the cleft, and then uniting the edges after the toes had been pressed together. A more shapely and sightly foot was thus obtained. The child was one of several who suffered from a similar deformity, and her mother, herself affected, feeling the inconvenience of such a foot, had taken her to the hospital to see whether something could be done to remedy the defect. The authors showed a family tree, from which it could be seen that the deformity affected three generations. The first to suffer was the child's grandmother, and of thirty-six lineal descendants sixteen were malformed; the malformation was perpetuated through the female branches of the family. It was singularly uniform in its manifestations, and was attributed originally to a fright. The patient and several members of her family were exhibited.—*Lancet*, April 9, 1887. [G. B. P.]

Bangs (L. B.) on the Diagnosis of Hypertrophied Prostate, and the Treatment of its Effects.—The writer's experience teaches him that well-to-do

elderly gentlemen are often so over-sensitive when being questioned regarding their urinary organs that a good history is sometimes hard to obtain. In such people, too, the doctor's orders are very often neglected; hence treatment is not always successful. Hospital patients are more manageable.

In the treatment, if the attack of retention of urine is acute, diuretics are not advised, as it is the author's opinion that in all acute conditions of the genito-urinary organs it is better to avoid all medicines and drinks which increase the quantity of the urine, for it has seemed to him that it is the increased functional activity of the parts which often aggravates the patient's sufferings. It is true that there are times when a too highly concentrated or super-acid urine will act as an irritant, but in my observation patients suffer more from frequently passing a large quantity of watery (yes, alkaline) urine, the result of diuretics, than they do from the smaller quantity of normal urine. During acute stages it is wise to secure as much physiological rest as possible, and therefore I endeavor to reduce the activity of the kidneys and bladder by stimulating that of the skin and bowels. In patients with enlarged prostates who have retention of urine, the bladder should be emptied and *washed out* at regular intervals. Too much stress cannot be laid upon the importance of washing out the bladder, but it is an art, and the frequency with which it is done and the solutions used must be adapted to each case. When properly done and persisted in, the comfort attained by the patient is, in some cases, remarkable. One patient with hypertrophied prostate, an old gentleman of nearly eighty, who cannot urinate without the catheter, has intervals of six or eight hours between the acts of urination, achieved by the most careful and persistent washing with simple warm water with a little salt in it. He has been under my care for over six years. At times, from some indiscretion in diet, or from some over-fatigue, or from neglect of washing the bladder, he has had a return of frequent urination, occasionally as often as every two or three hours night and day. On these occasions I have had him washed out frequently during the day, and sometimes as often as he urinated, especially if there was any increase over the usual amount of mucus in his urine. In a few

hours the intervals would begin to lengthen, and in a day or two be normal again. If his urine is superacid I give him benzoate of lithium in the Buffalo lithia water, and the effect upon his urine is a very speedy one, without any disturbance of his digestion. For this washing of the bladder I prefer to use weak solutions of common salt rather than carbolic acid, oleate of lead, or sulphate of zinc, and the like. There is one "little thing" connected with the washing of the bladder which I have come to regard as of considerable importance. The patient or his body-servant should be taught to carefully siphon out the last few drops of urine, or mucus, or pus—the dregs, so to speak—from the bottom of the bladder. It is done in this way: After the last drop of urine or of the washing solution has escaped from the catheter, let the patient make a final effort of straining, and at the same instant close the finger tightly over the mouth of the catheter, and keep it there while the latter is withdrawn. In the eye of the instrument or in its lower inch or so will be found a column of urine and of mucus, or muco-pus, as the case may be, which would certainly have been left behind to trouble the bladder.

In order to keep the catheter pure and free from germs, absolute cleanliness must be enjoined. It is not sufficient to give these patients a solution of carbolic acid, or of some other antiseptic, and trust to their keeping the instruments in it all the time. My observation has led me to direct them to wash their catheters with hot water and soap immediately, or as soon as possible, after each using, till the ordinary odor is entirely removed, or, for want of a better guide, until they are willing to put the instrument in their mouth. After that they may keep it in an antiseptic solution if they choose.—*N. Y. Med. Four.*, May 14, 1887. G. B. P.

Sands (H. B.) on Obstinate Hemorrhage after Amygdalotomy; Recovery after Ligation of the Common Carotid and Infusion of Salt Solution.—At a meeting of the New York Surgical Society, Dr. Sands narrated the case of a man, twenty-four years of age, who had both tonsils excised with a tonsil-guillotine by Dr. Fuller at 4 P.M. The hemorrhage following the operation was insignificant. The patient went home, dined, and in the evening went to a wedding, at which he was

to act as an usher. While there he began to bleed, and was obliged to return home. The hemorrhage continued all night, in spite of efforts made to control it by pressure with the fingers, large dressing-forceps, and styptic cotton. The bleeding was confined to the right side. The following morning Dr. Speir was called. He found the patient greatly prostrated, and still bleeding. He tied the right common carotid artery, but the hemorrhage continued, and transfusion had been thought of as a last resort. When the speaker saw the patient, the latter was extremely weak, and could scarcely speak, and his pulse was small and rapid, at times almost imperceptible. Blood was slowly oozing from his mouth. On examining his throat, no bleeding point could be detected, but only oozing from the right tonsil, which ceased after the clots had been scraped away with the finger, perhaps because a better surface was thus afforded for the deposit of coagulum. The speaker opened a vein in the arm, and introduced a pint of saline solution in the course of four or five minutes, using a Cohn's apparatus, with which any entrance of air was prevented. During the operation, the volume and tension of the pulse improved considerably. The speaker had been informed that the patient's subsequent progress had been favorable, and that he was now convalescent. How far the infusion had contributed to this fortunate result the speaker was unable to say, but it might have assisted the recovery by increasing the amount of liquid in the blood-vessels. It had been learned, after the removal of the tonsils, that the patient belonged to a family of bleeders, and that he had once before bled profusely after the removal of a tooth. The speaker did not believe that this explanation was satisfactory in the present instance, for, if the theory of the hemorrhagic diathesis had been correct, there should have been bleeding from both tonsils, and also from the wound made during ligation of the carotid. The hemorrhage was probably due to the division of a large tonsillar artery. The speaker added that this was the only case of the kind he had seen.—*N. Y. Med. Four.*, May 2, 1887. G. B. P.

Alexander on Removal of Advanced Cancer of Rectum.—At a meeting of the Liverpool Medical Institution, Dr. Alexander showed a patient from whom he had removed rather more than four inches of the rectum, by a method devised to insure

greater safety in operating on these cases of advanced disease, and more convenience and comfort after the operation has been a success than usually results either from colotomy or from leaving a sinuous track for the fæces to percolate through after excision of the rectum. His method consists in removing the coccyx and sufficient of the sacrum until the healthy bowel can be brought into the wound, and there stitched to the skin in the upper angle of the incision. The lower two segments of the sacrum can be dispensed with, without practical inconvenience of any kind to the patient, and this extent is all that is likely to be required in most cases. To remove more would injure some of the nerves of the sacral plexus. Before operation the anus is filled with antiseptic gauze, and the rectum is not opened until the operation is almost complete, thus allowing a more antiseptic condition of the wound than is obtained when the rectum is slit open at the commencement of the operation. After the coccyx and a piece of the sacrum have been removed, and the healthy bowel fixed into the angle of the diseased wound as described, the rest of the rectum is cleared from the urethra, prostate, and base of the bladder in front and from its lateral connections, all *actively* bleeding points being compressed or tied. When the peritoneum is reached it may, as in this case, be pulled off until the sound bowel is reached all round. The diseased rectum, now free from its surroundings, is pulled into the angle of the wound, and the healthy part above is stitched to the skin with numerous sutures. The edges of the lower or anterior part of the wound are now brought together, and then the diseased part is removed. Some more sutures of silk-worm gut are then inserted, to firmly connect the skin and bowel, and the patient put to bed with absorbent wool applied to the wound. This is changed frequently. The stitches are removed as soon as they show signs of irritation, and the bowels kept free, all fæces being washed away with perchloride lotion as soon as passed. The patient shown was æt. 45, a fish porter, who was in a most pitiable state when he applied for relief. He was operated on on Feb. 2d, and although he tore open the anterior wound on the third day after, by getting out of bed, he made an admirable recovery. He has an artificial anus in a place very little removed from the usual anal site. He can retain his motions, and has gone back to his work.

There is as yet no sign of any recurrence of the disease.—*The Medical Press*, May 18, 1887. G. B. P.

Ventrotomy.—According to Reeves,¹ there is much need for a single and simple word to express the operation of opening the abdominal cavity, for whatever purpose. "Abdominal section" is long, and has to be supplemented by saying for what object the operation was undertaken; thus, one would have to say, abdominal section for the exploration or removal of an ovarian or uterine growth. "Laparotomy" strictly means section of the flank. "Malacotomy," recently suggested by Mr. Rabagliati, simply means cutting soft parts, and can be applied correctly to other regions.

He says: "I would therefore suggest the use of an etymologically hybrid word, namely, 'ventrotomy.' 'Gastrotomy' is properly limited to operations on the stomach, and as I know of no English word or combination sufficiently short and explicit, the word suggested seems to me to answer the purpose. At first sight, it would appear that such words as gastrotomy, nephrotomy, etc., suffice; but these organs can be reached by various ventrotomies, and in statistical comparisons precision is necessary. We have it if we speak of a median, anterior, lateral, and posterior or lumbar ventrotomy; thus, the first is through the linea alba, the second at the outer border of the rectus, the third in the flank, and the fourth in the loin. If I wished to accurately describe a gastrotomy done through the linea alba, I should say median ventro-gastrotomy; if to describe a lateral one done beneath the costal cartilages, I could say, subchondral gastrotomy. Similarly, one could accurately describe operations on the kidneys by making use of the terms median, anterior, or posterior ventro-nephrotomy or nephrectomy. It may be said that the prefix 'ventro' is not necessary, but I urge that for purposes of accuracy in record, it is not merely desirable, but actually necessary.

"Last year, I suggested at the British Gynæcological Society that the nomenclature of kidney-operations would be made more accurate by the addition of a few letters, for nephrotomy may be done on a healthy kidney or in one containing pus or urine, and that the term pyo- or hydro-nephrotomy would sufficiently define opera-

¹ H. A. Reeves, *Br. Med. Jour.*, March 12, 1887.

tions done for pyo- or hydro-nephrosis; and that, if a stone be removed from a suppurating kidney, the term nephro-pyolithotomy, though rather long, has the great advantage of being accurate, and shorter than saying or writing its equivalent in accuracy, namely, nephro-lithotomy in a purulent kidney. The abdominal wall may be incised without opening the peritoneal cavity, and I would provide for this by prefixing the word 'superficial.'

N. Davies-Colley¹ objects to the hybrid word "ventrotomy" and suggests the use of "coeliotomy," from the two Greek words, "abdomen" and "to cut."

Wyman (H. C.) on the Tooth-Brush in Plastic Surgery.—The principle, concerned in the use of this instrument as an agent for controlling hemorrhage, is the same as that which operates in the use of the curette in various intra-uterine surgical operations, viz., a laceration or teasing of the blood-vessels, so that the blood corpuscles become entangled in a mesh of fibrous tissues and thereby plug the vessels, preventing the escape of blood. Or the internal coat of the small vessels retracts and plugs the opening from which blood would otherwise escape.

When the incision is made and the blood begins to ooze freely from its sides and bottom, the brush is stroked briskly over the wound, constantly brushing away the blood as it oozes out, until, under the frequently repeated brushings, the cut vessels are frayed or teased out, and the mesh of lacerated tissues traps the blood corpuscles and coagula, preventing further hemorrhage.

The author has employed this means of checking hemorrhage in the following operations: removal of part of posterior vaginal wall; lacerated cervix; recto-vaginal fistula; lacerated perineum; urethral polypi; cleft palate; hare lip; removal of cicatrices and nævi from the face, and in other operations mostly of a plastic character.—*New Eng. Med. Monthly*, April, 1887.

Chismore (G.) on Some Cases of Pyelitis in Which Frequent and Painful Micturition was the Chief Symptom.—Two cases in particular were cited to call attention to the fact noted in the books but not sufficiently emphasized,

namely, that frequent and painful micturition might be so pronounced a symptom in pyelitis as to mislead the experienced observer as to the nature of the case, and cause him to address treatment to the bladder alone while the real malady was in the kidneys. In one of his cases, in which frequent and painful micturition was the chief symptom, the man had sustained a violent muscular strain in the region of the kidney, and for some years afterward suffered in the extreme, and was treated for cystitis by some of the most distinguished specialists; but finally the abscess of the kidney discharged and the patient recovered.

In the second case, treatment was directed to presumable cystitis, and at the autopsy the kidney was found riddled with abscesses. He asked, how many times has the healthy bladder been subjected to every variety of persistent treatment, while disease of the kidneys has gone on, only shown to be present by post-mortem examination? He believed that in many cases the diagnosis of pyelitis could be made only by exclusion.—*Med. News*, May 28, 1887.

Cabot (A. T.) on a Case of Hysterectomy for the Relief of Pyelitis from Obstruction.—The author had a patient in August, 1886, who died from uræmia with suppression of urine, caused, as proven on autopsy, by pressure of a uterine fibroid upon the ureters as they passed over the brim of the pelvis.

In December of the same year a woman was referred to him by Dr. Garland, of Gloucester, who, superadded to an easily demonstrable uterine fibroid, developed almost unquestionable signs of pyelitis. At a first operation a sloughing ovarian cyst was removed, and at a second the fibroid and all the uterus except a small remnant of the cervix. The renal symptoms were relieved, and at the time of reporting the case convalescence was nearly complete.—*Bost. Med. and Surg. Jour.*, June 2, 1887.

Copeland (W. P.) on the Treatment of Burns.—A young man received severe injuries in a boiler explosion, his face, ears, and hands being very badly burned. At the time I saw him, some weeks after receiving the burn, he was being treated by daily removals of the dressings, washing the parts with warm water and castile soap, then dusting the

¹ *Brit. Med. Jour.*, March 26, 1887.

entire burn with subnitrate of bismuth, followed by a reapplication of the bandages anointed with cosmoline. The patient was rapidly acquiring the morphine habit, by reason of the large doses given for the relief of pain, and the burn was doing badly. I had the dressings left off, and put the hands in pasteboard boxes without any bandages, not allowing anything to rest on the burned surfaces. The ends of the boxes were cut out to fit the wrist, and they were covered with mosquito-netting to keep off flies. The face and ears were left unbandaged also, with mosquito-netting so arranged as not to touch the burned surface. On the next day the burned surface had become dry and was covered with a thin film of scab, which gradually thickened. When pus was found to be accumulating under the scap a small opening was made at one edge, and the secretions were pressed out by means of a soft dry piece of lint. The case progressed satisfactorily and speedily to a cure, with very little disfigurement.

The method, too often adopted, of daily washing off burns or open wounds with water, and removing the secretions, only breaks up the delicate adhesions that have taken place since the last dressing, and keeps up the irritation by pulling off and washing away the very substance with which nature is trying to repair the injury. —*N. Y. Med. Record*, May 7, 1887.

Homans on Drainage of Abdomen in Tubercular Peritonitis.—The case was one of supposed ovarian disease in which, on opening the abdomen, the peritoneal cavity proved to be filled with fluid and the peritoneum itself, studded with tubercle, as was shown by the microscope, a piece being removed for the purpose. The fluid was removed and the wound closed. The patient made a good recovery, after long drainage (eight months), and is now fat and healthy. Another case, supposed to be ovarian cyst, or a cyst of the broad ligament in a seemingly healthy girl of seventeen, who had a fat abdomen, proved to be tubercular peritonitis, with ascites. One Fallopian tube and one ovary which were thickened were removed, together with bloody serum. The peritoneum was dried as thoroughly as possible, and a glass drainage-tube introduced. The patient recovered and now looks well. —*Bost. Med. and Surg. Jour.*, June 9, 1887.

Varick (T. R.) on the Application of Hot Water to Operation Wounds.

—Referring to Wylie's recent advocacy of the above procedure, the author writes to the *N. Y. Med. Jour.*, January 11, 1887, to substantiate his claim to priority for this method. He refers to an article of his in the *Four. of the Am. Med. Ass'n*, vol. iii., p. 372, where he uses the following words:

"It has been my practice for many years, after the vessels have been tied, to sponge the surface of the stump with water a little below the boiling point, not only for the purpose of dislodging any coagula that may have formed in the interstices of the tissues, *but to stop further oozing.*"

And again in the *N. Y. Med. Jour.*, vol. xli., p. 237, where he says:

"My practice is, and has been for nearly six years, immediately the larger vessels have been tied, *to apply water slightly below the boiling point freely and continuously to the abraded surface* until all oozing is stopped, the parts are thoroughly glazed, and the red hue of the tissues is slightly deadened. . . . The effect is not only to form the protective shield before mentioned from autogenous material, which is always available, *but it mitigates shock, it promotes reaction*, and accelerates healing in a marked degree." After considering the question of shock, both primary and secondary, I further remarked: "It is under these circumstances that the stimulating effect of heat transmitted to the heart is most marked. . . . Before I adopted the method of treatment under consideration, many patients died after apparent reaction from primary shock in the manner described above; since its adoption, no death from either primary or secondary shock has occurred in my practice."

Thomas (O.) on a Sawdust Surgical Dressing.—The formula employed is as follows: Crude pyroligneous acid, one gallon; bichloride of mercury, thirty grains; water, two gallons; this is used to charge a quarter of a sackful of sawdust. The pyroligneous acid can be got in a crude state from the tar distillers by surgeons who prefer to make the preparations for themselves. The surgeon is recommended to cover the part or bury a portion of the limb in the prepared sawdust, immediately covering the sawdust with either gutta-percha tissue or sheets of tinfoil. Mr. Thomas states that if he uses it for com-

pound fracture of the hand or wrist he applies bare sheet-iron, and shapes it to the part for the purpose of fixation, and the whole is then covered with an ample quantity of the dust, retained in place by a cloth and bandages. The same plan is followed with other compound fractures.—*Br. Med. Jour.*, April 16, 1887.

DISEASES OF THE UPPER AIR-PASSAGES.

Hay Fever.—At the last meeting of the Am. Laryngological Association, Dr. J. O. Roe read a paper on this subject, and bases certain conclusions upon his experience in forty-two cases.

First.—That all cases of hay fever have their initial lesion in a diseased condition of the nasal fossa.

Second.—That disease of these tissues is reflected to other tissues.

Third.—That sensitive areas of the nose are not confined to any particular locality.

Fourth.—That the direction in which the irritation is reflected is always in the line of least resistance, in one direction at one time and in another at other times.

Fifth.—That disease of the nose may produce disease in other parts of the respiratory tract, which may become an independent source of irritation.

Sixth.—That hay fever is due to the effect of local irritation brought in contact with the sensitive regions of the air-passages.

Seventh.—That the disease is not, *per se*, a neurotic disease, nor is a neurotic condition necessary to render patients sufficiently sensitive to local irritation of the air-passages, and it is not necessarily associated with the nervous development.

Eighth.—That the neurotic condition is often developed as the result of the local irritation.

Ninth.—That by careful and judicious treatment of the disease of the nasal tissues and that of other portions of the respiratory passages below and secondarily affected, and by combining with such treatment the systemic medication that may be necessary to remove the general derangement, we need not fail to cure hay fever.

In a lecture by Sir Andrew Clark, published in the *London Lancet*, of June 11, 1887, the following method of treatment of hay fever is proposed. The nostrils having

been thoroughly cleansed by means of a douche of boroglyceride, in the proportion of an ounce to the pint, the nasal fossæ are to be treated with a solution of glycerine of carbolic acid one ounce, hydrochlorate of quinine one drachm, and a thousandth part of perchloride of mercury. Heat is required to make a perfect solution of the quinine. The application is made with the laryngeal brush every second or third day, according to the amount of local reaction, which is sometimes considerable. A single such application has been known to prevent an attack for a season, and in four cases there was never a recurrence of the disease. Generally, two or three applications are necessary. Constitutional treatment is not neglected, if indicated. C. H. K.

Case of Myeloid Sarcoma, Involving Both Superior Maxillary Bones, Together with the Hard and Soft Palate; Removal of Growth with the Greater Part of Both Bones; Recovery.—Dr. F. Bowreman Jessett gives the history of this interesting case in the *London Lancet*, May 28, 1887. The patient was a woman, thirty-five years old, whose family history was good, except that her grandfather died of epithelioma of the lip. Twenty-one months ago she first noticed a lump in the hard palate. It grew rapidly, and interfered at length with mastication and speech. At the end of six months the growth was removed with scissors, and its base was scraped. The wound healed nicely. A year later she presented herself with extensive recurrence of the disease. It implicated the whole of the hard palate and the inner aspect of the gums as far forward as the first molar tooth. The soft palate was infiltrated to within a quarter of an inch of its free margin. The tumor pressed back upon the posterior wall of the naso-pharynx and protruded upwards into both nostrils, especially the left, so that nasal respiration was impossible. The patient suffered but little pain. She complained chiefly of difficulty in eating, on account of the presence of the growth, which was the size of a large lemon, as it appeared in the mouth. Two incisions were made, one from either angle of the mouth, upwards and outwards towards the external canthus. The flap thus formed, including the nose, was dissected up and reflected upon the forehead. In this manner the front of the growth and the superior maxillary bones were exposed. With a fine

saw the bones were divided half to three-quarters of an inch above and parallel to the alveolar process. By means of a rasp, this portion of the bones was detached from the upper parts. It was then seized with lion-toothed forceps, the index finger introduced into the pharynx meanwhile pressing the tumor forwards. Thus the excised bones were withdrawn, together with a large part of the tumor. A small portion which had grown into the antrum was subsequently easily removed by means of Volkmann's spoon. There was but little hemorrhage. The patient bore the operation well. For the first twenty-four hours she was fed by enemata, and afterwards through an india-rubber tube passed into the mouth. The external wound had united by the end of a week. Three months after the operation the patient was entirely well. Her speech, with the exception of a few letters, was peculiarly good, and there was little or no deformity. With the aid of a plate it was expected that ability to masticate might be gained.

This case represents well one of those rare cases in which the practice of removal of the greater part of both the superior maxillary bones may be practised with advantage. In performing the operation I preferred adopting the primary incision, as suggested by Heyfelder, as, from the size of the growth and the uncertainty of its deep attachments, I thought these incisions would afford the greatest possible amount of room for the removal of the tumor, and also in case of deeply seated hemorrhage, occurring during or after its removal, these incisions would enable me to obtain the best view of the deep parts. After having fully exposed the tumor, by reflecting the flaps upwards instead of attempting to pass a chain saw through the spheno-maxillary fissure, which in this case would have been impossible to accomplish, I preferred to saw through the maxillary bones from the front, and then by inserting a chisel into the divided bone to separate the alveolar processes and lower part of the bones from the upper. By this means I avoided wounding the growth, which was very vascular, and I was enabled to remove it with its attachment entire. Had I persevered and thrust the chain saw through the spheno-maxillary tissue and sawn through the bone from behind forwards, it is evident that I must have divided the growth as well, and in all probability met with very considerable hem-

orrhage. By adopting the method of dividing the bones, I was enabled to preserve the pterygoid process of the sphenoid bone intact, which is of very great importance. Had the disease extended deeper than it did, by removing the lower portions of the bone by this method, it would have been easy, by means of the gouge or gouge forceps, to remove as much more as might have been necessary. Doubtless, this method of proceeding has been adopted by other surgeons but I have been unable to find any case so operated on recorded.

C. H. K.

Foreign Body in the Air-Passages.

—In the London *Lancet* of May 28, 1887, Dr. Chas. Boyce relates an unusual case. The patient was thrown from his dog cart and remained unconscious for some time. Afterwards there was considerable ecchymosis of the face, but no pulmonary symptoms, except on lying down, when the breathing became whistling. More than two months later, no serious symptoms having meanwhile developed, the patient accidentally swallowed a fish-bone, and, during the attack of convulsive coughing thereby excited, he expelled the vulcanite mouthpiece of a pipe he had been smoking at the time of the accident. It is supposed that the foreign body lay across the bifurcation of the trachea, and that the peculiar whistling breathing, while in the recumbent position, was due to more or less projection of the body into one of the bronchi.

C. H. K.

Splinter of a Rifle Ball Removed from the Left Ventricle of the Larynx.

—This case is reported by Dr. David Newman in the *Glasgow Med. Journal*, May, 1887. The patient, a marker at a rifle range, was wounded on the right side of the larynx by a splinter from a ball fired at a distance of five hundred or six hundred yards. The wound was small, but was followed by considerable inflammation of surrounding parts. With the laryngoscope under cocaine, a small dark body could be seen on the right side of the larynx. It was seized and removed with Schroetter's forceps. The foreign body, a piece of lead, measured one quarter of an inch by one sixth of an inch, was triangular in shape, and not thicker than a visiting card. At one point it had a metallic lustre, from which it was inferred that a fragment remained imbedded in the thyroid cartilage. The use of the voice was completely recovered, the

unusual thing being a slight clicking in the larynx when he performs certain movements.

C. H. K.

Garel (J.) on a Case of Hemorrhagic Laryngitis.—The patient was a man of fifty-five, subject to attacks of rheumatism and with a tendency to hemophilia. During a rheumatic attack he suffered from a painful sensation in the larynx without expectoration of blood or change of voice.

Later the voice became husky, and on waking there was some dyspnoea, relieved by the expectoration of some firm dark blood-clots.

On examination the patient was found to be in a state of general debility. He had mitral insufficiency.

On the free edge of the vocal cords there were seen to be black blood-clots forming a sort of ragged fringe.

Similar clots were on the arytenoids and epiglotti. The upper surface of the cords was of a rosy tint but not ulcerated. The motility of the cords was intact, but the clots prevented their exact approximation. The patient succumbed in a few months from an aggravation of his cardiac affection.—*Rev. Mens de Laryng.*, etc., May, 1887.

R. W. A.

OBSTETRICS AND DISEASES OF WOMEN.

Carrigei on the Use of Ipecac. as an Aid to Labor.—The author was led to experiment with this drug, remembering how potent it was in checking uterine hemorrhage, and is satisfied that ipecac. is a powerful oxytoxic, which stimulates the uterus and at the same time tends to dilate a rigid cervix. According to him, pains which are severe but unavailing are by this drug converted into pains of an expulsive nature, and more endurable. In many cases he has seen the os, closed and rigid after many hours of labor, become relaxed and the labor terminate in an hour after the administration of two to four grains of powdered ipecac.—*Rev. Méd.-Chir. des Mal. des Femmes*, May 25, 1887.

Mann (C. A.) on Occlusion of the Vagina.—February 20, 1872, I was called to visit Mrs. J. G., and found her in labor. She was a primipara, and had been in labor twenty-four hours, attended by a female "accoucheur" of limited notoriety and

of quite limited ability. Her numerous vaginal examinations and her "digital solicitude" had made the vagina very sore and painful. I endeavored to re-establish uterine action; succeeded after a time, and finally the labor was over. I had some difficulty in delivering the placenta on account of the very sensitive condition of the parts. I gave directions to have the vagina washed out with warm water and syringe, and gave explicit caution in regard to the matter of after-treatment.

About three months afterwards Mrs. G. came into my office, and said that recovery from her late accouchement had been quite slow and unsatisfactory. I found an extensive indurated cicatrization, almost completely closing the entire length of the vagina. The orifice left would not admit the end of the index finger. The tissues were hard and resisting. Copulation would have been impossible. I informed the woman and her husband that an operation was required to restore her to the normal condition.

Fifteen months afterward (May 4, 1873) Dr. Martin Moore came in haste to my office, and desired my assistance in an obstetric case. I found, on examination, that the patient was in labor. The vagina was in precisely the same condition as at my last examination in my office. The husband informed us that he had had no satisfactory copulation since her last confinement. We could with great difficulty learn that the presentation was "natural"; the head had descended into the pelvis, satisfactory dilatation could not take place, and the uterine contractions had ceased entirely.

We placed her under the influence of chloroform. I at first attempted to break up the adhesions with the handle of the scalpel, but the adhesions were firm and extensive. Then with the index finger of the left hand in the rectum and a catheter in the urethra to serve as guides, in order to avoid the formation of fistulæ, I dissected the entire vagina to almost its normal size. As hemorrhage was profuse, by the aid of Hodge's forceps I delivered her at once. We then permitted her to pass from under the influence of the anesthetic, delivered the placenta, and one of us remained with her during the night. She made a good recovery, received daily medical attention from Dr. Moore or myself, and by keeping a drainage-tube in the vagina, with medicated tampons, and giving

injections, adhesions of the vaginal surfaces were prevented, and complete recovery accomplished.

The woman still lives, and the husband informed us that she is a "*natural* woman now."—*St. Louis Cour. of Med.*, Oct., 1886.

Nilsen on Pregnancy with Almost Complete Occlusion of the Vagina.—

A young lady (unmarried) had missed two periods and suspected herself to be pregnant, having incurred the risk of becoming so. On examination, she was found to present the usual mammary signs of that condition. There was an atresia of the vagina, the canal being closed by a membranous septum, about a quarter of an inch thick (situated one and one half inches from the vulva), in which was a small opening that barely admitted a fine probe. He incised and dilated the septum four or five different times, and introduced a glass plug. The patient made a perfect recovery, although she miscarried after one of the operations.—*Am. Four. Obstet.*, etc., June, 1887.

Walton on Membranous Dysmenorrhœa in a Virgin; Forced Dilatation; Discision of the Cervix and Curetting.—The patient was 24 years old and ever since her first menstruation at the age of 14, had, each month, suffered atrocious pains, and expelled more or less voluminous folds of membrane. The microscope showed the debris to be uterine mucous membrane.

The cervical canal was dilated, and the cavity of the body was thoroughly curetted. At the time of reporting the case, six months after the operation, menstruation still remained normal.—*Ann. de la Soc. Méd.-Chir. de Liège*, April, 1887.

Chéron on the Treatment of Fetid Leucorrhœa by Injections of Potassium Chlorate.—In relation to ordinary cleanliness the following formulæ should be employed: Tincture of opium 10 parts, chlorate of potassium 12 parts, take water 300 parts. Two or three teaspoonfuls of this mixture are added to a quart of tepid water for injection morning and evening. With this liquid M. Chéron advises continued irrigation lasting 5-10 minutes.—*Rev. Méd.-Chir. des Mal. des Femmes*, May 25, 1887.

Frazer (W.) on a Case of Double Vaginal Orifice.—I attended a lady some time since who consulted me about the sixth month of her pregnancy; she had

previously borne several children, with natural and easy labors, but for upwards of eight years before coming under my observation had ceased to conceive. She complained of an inconvenient swelling of the labia, which she thought was caused by a varicose condition of the veins, as the veins of the lower limbs were also swollen. This induced me to examine her with carefulness. I noticed that a projection about the bulk of a small apple sprang from the left side of the vagina, of dark purple color, and consisting in great part of swelled veins. However, a closer examination detected that it was adherent only above and below—in fact, it constituted a perfect partition, extending upwards to the vagina for about an inch and a half; on one side was the usual orifice in the clitoris and urethra, and on the other a miniature opening of a smaller but well defined second passage. This supplemental vagina was quite unknown to the patient, who had never suspected its existence. It was capable of distension until two fingers could pass in; above, it terminated in the vagina common to both passages, and the uterus was perfect and normal. Delivery came on at its usual time, and was completed, as it always had been, without difficulty and by the larger passage, the septum lying to one side like a valve. In the course of a few months I obtained permission to examine the condition of parts. As all trace of swelling and varicose veins had passed away, this presented no difficulty. The septum in its structure was similar to the labium, and like it studded with the usual hairs; the natural orifice had its urethra, clitoris, and the lesser labiæ of small size; the supplemental opening had minute but distinct lesser labiæ, and a distinct fourchette; there was no trace of clitoris; the vaginal orifice was perfectly formed and surrounded by a strong and distinct sphincter muscle.—*Medical Press*, May 4, 1887.

Pajot, on the Treatment of Eclampsia.—The author cautions against ever inducing premature labor. He urges that the proper medicinal treatment be instituted, and that nothing further be done while the os remains undilated. If the os is dilated, the cavity of the uterus should be emptied at once, provided it can be done without using undue violence. After delivery, the medicinal treatment should be continued.—*Rev. Méd.-chir des Mal. des Femmes*, May 25, 1887.

Higgins (W. S.) on Vomiting in Pregnancy.—The patient is invariably a *married lady* who is unable to endure *all* the amorous husband is *anxious* to give.

After thirty-seven years' active practice I have the first patient to prescribe for who was abundantly able to satisfy the desires of a weaker husband. Making a note of that fact some ten years ago, I adopted a course of treatment accordingly.

First stimulating the passions with appropriate remedies and requiring *rest* from the desires of the husband. Since adopting that as the true cause and prescribing accordingly, I have had the great pleasure of relieving each patient in a very short time. I have found *tr. cantharides* and *tr. ferri mur.*, equal parts, to suit a majority of cases admirably. Dose, 25 drops in water three times daily.

After ten years proving this as the true course to pursue with the distressing malady, I feel now justified in giving it to the profession.—*Peori Med. Mo.*, April 1, 1887.

MISCELLANEOUS.

EAST AVON Co., N. Y.,

May 19, 1887.

Editor Medical Analectic,

DEAR SIR:—The following will be found a most excellent application used with an atomizer in difficulties of the throat, as pharyngitis, tonsillitis, pharyngeal catarrh, hoarseness, etc. :

℞ Menthol crystals . . . v. to x. grs.
Glycerine 3ij.

Rub up until crystals are dissolved and add :

Alcohol 3j.
Water q. s. ad. . . . 3j.

SIG.—Use with atomizer frequently.

G. W. SQUIRES, M.D.

Dillenbaugh on Antipyrin in Dysmenorrhœa.—Some time in July or August of last year it occurred to me that if antipyrin will relax a hyperæmic and dry skin by virtue of its action on the vaso-motor dilator centres, why will it not relieve an evident hyperæmia of the endometrium? In the first case of painful menstruation to whom I gave it, one of essential and oft-repeated trials with opiates and stimulants of all kinds with their unpleasant sequences, the antipyrin gave immediate and continued relief for that menstrual period, though the patient took

but one dose of fifteen grains. Since then I have found that repeated doses of five grains do not afford the relief obtained by an initial dose of fifteen to twenty grains.—*N. Y. Med. Record*, May 21, 1887.

Stearns (J. H.) on an Original Suture.—The stitch is made by inserting the needle at a suitable distance from the edge of the cut, parallel with it, bringing it out a quarter of an inch or more from the point; then carry it over to the other side, and make a like stitch; then tie the two ends together. You thus have a rectangular suture that holds the parts securely, and does not complicate the wound.

Where there is little strain a continued suture can be employed on the same principle.

It can be seen that by drawing the thread a little snug, in closing an intestine, for instance, where the mucous surfaces will not unite, the serous faces will be brought together, and a prompt union thus secured.

In the ordinary suture the thread draws upon a single point, and soon begins to cut its way out. With this stitch it draws upon the whole width of it, and if it requires to remain in more than six days the drop of pus which is usually found is outside of and does not complicate the wound.—*Med. Register*, April 16, 1887.

Kelly (C. J.) on a Curious Effect Produced by Creasote.—I met a patient of mine a few days ago, and was astonished to find that he had become quite gray since I had previously seen him, a week before. I asked him did he know the reason of this sudden change? and his reply was: "I told everybody it was a fright I got, but I will tell you the truth. On last Friday I was going to a dance, and I put on my hair what I believed to be hair-oil. My scalp tingled and pained me frightfully. I thought no more of it then, but next morning my hair was beginning to get gray, and every day since it was getting more gray. It was creasote that was in the bottle, and not hair-oil." This man is about thirty-five years of age; he is the youngest of a family of five. The other members of his family have the same colored hair they had twenty years ago.—*Provinc. Med. Jour.*, May 2, 1887.

Miot (C) on Obstruction of the Eustachian Tube among Diabetics.—From his experience the author believes it demonstrated that a tumefaction of the tube with œdema can be called a

complication of diabetes, and that ordinary treatment is futile. By means of galvanism he lessens the congested state of the mucous membrane so that bougies can be introduced and application of the galvano-cautery, which he considers the quickest and most efficient treatment, made.—*Rev. Mens de Laryng., d'Otol., etc.*, June, 1887. R. W. A.

Alexander (J.) on Poisoning by Nutmeg.—A patient ate one nutmeg as a cure for diarrhœa, and all next day he was stupid, giddy, and very drowsy; the symptoms passed off with the use of castor oil and strong coffee.—*Br. Med. Jour.*, May 14, 1887.

Vomiting of Pregnancy.—Lubelski claims to have successfully treated the vomiting of pregnancy by the application of ether spray to that part of the spine which is opposite to the epigastric region. The application should last from three to five minutes, and be repeated every three hours. In bad cases a spray of chloroform should alternate with ether.—*Rev. Méd.-Chir. des Mal. des Femmes*, May 25, 1887.

Pickle for Pathological Preparations.—The preserving liquid of Grawitz is prepared as follows: 150 grms. of common salt, 40 grms. of sugar, and 20 grms. of saltpetre are dissolved in 1 litre of water. This solution is acidulated by the addition of 3 per cent. of boric or tartaric acid. The acid is necessary on account of the decomposition of the hæmoglobin of the hæmatin. When the preparation is placed in the liquid, water is added until the object sinks in it. The pickle is ready in from four to eight weeks, when the objects are taken out and placed in fresh clear pickle. The quantity of water that requires to be added is from one third to one half. The vessel should be filled brimful, so that when the cover is placed on, no layer of air should remain under the cover; the cover should touch the liquid.—*Med. Press*, April 27, 1887.

Prudden (T. M.) on Multiple Adenomata of the Kidneys.—The subject was a man who died of an injury. In this case the tumors were multiple, which was not so very common; they occurred in both kidneys, which again was not very common. They illustrated the two forms in which adenomata occurred,—the alveolar and the papillomata. They

were sharply circumscribed, and varied in size, showing the progress of the growth. Some were brown, some white, the difference in color being due to the deposit of pigment in the brown ones.—*Med. Times*, April 30, 1887.

Handford on Fatty Tumor in the Interauricular Septum of the Heart.—The patient was a woman, æt. seventy-six. Dr. Handford mentioned that he could find but three instances of a similar growth recorded in medical literature. Even the great museums in the country do not possess an undoubted specimen of such tumors, and no description of them had been hitherto given at the meetings of the Pathological Society. The example in question was of the size of a small pigeon's egg, well defined but not encapsuled, and when cut it presented all the characters of an ordinary lipoma.—*Med. Press*, Jan. 26, 1887.

Morel-Lavallée (A.) on Aconite Poisoning.—A doctor suffering from a painful cough, took about 30 minims of tincture of aconite root. In an hour he felt extremely weak and sick, suffered from vertigo and went to bed. He was first seen two and a half hours after the ingestion of the poison. The teeth were clinched, the lips numb, the extremities cold, tingling, and devoid of sensibility. The patient complained of coldness and a feeling of impending death comparable to that of angina pectoris. The pulse at this time was irregular, filiform, intermittent and by actual count only 14 per minute. The lips and entire surface of the body were pale and cold. A feeling of constriction about the epigastrium was present. The treatment was energetic and successful. Hypodermics of ether, a pint of strong coffee, two bottles of champagne, two drachms and a half of the acetate of ammonia, hot-water bottles and dry frictions. A period of cerebral excitement, followed this course of medication, during which the pulse went up to 76. Convalescence was perfect, although for the next eight days the pulse ranged between 42 and 52.—*La France Méd.*, May 28, 1887.

St. Clair (R. W.) on Housemaid's Knee Cured by Electrolysis.—Charles S. —, aged 16, and a boot-black, came to me with a soft and fluctuating swelling, hemispherical in shape, unaccompanied by

¹ See MEDICAL ANALECTIC, 1886, p. 207.

² See MEDICAL ANALECTIC, 1886, p. 17.

discoloration of the skin, and enlargement of the subcutaneous veins. There was some soreness, caused from over-exertion at his work. It had been diagnosed as a "venous tumor," but the absence of the bluish color, and no pain through the femoro-tibial articulation, and not being partly effaceable under pressure, and no hypertrophied and varicose veins, led me to decide it a housemaid's knee. I decided to perform electrolysis upon it, and I did. I inserted three needles (*negative pole*), and the *positive* pole was placed on the calf of the leg. The current was turned on, and kept on for eight minutes. The boy was the whole support of the family, and could not remain in bed. The operation was repeated in six days, and every sixth day for five weeks. The tumor entirely disappeared, and the knee is as good as the other one, to-day. The great advantage of the treatment in this case was, that he did not have to quit work (though he did not kneel down), and was not confined to his bed. Then the pain was not so bad as if it had been cut, and the cure is perfect.—*Med. World*, June, 1887.

Kesteven (L.) on Sunstroke in an Infant; Hyperpyrexia; Death.—H. N—, female, 6 p.m. on February 21, 1886. It was a very bright summer day, and the heat had been intense during the afternoon, and her mother stated that the child had been just running in and out of the room on to the veranda, but that at no time could she have been many minutes out in the sun, as she did not remember losing sight of her at all. At five o'clock in the afternoon the child appeared giddy, was squinting markedly, and soon afterwards went into convulsions. At six o'clock, when I saw her the convulsions were confined to the right side, and the child was comatose. I put it into a hot bath at once, and poured cold water on its head. At seven o'clock I took the temperature first, and found it to be 105.2° F. The convulsions continuing I gave an inhalation of nitrite of amyl. This produced the physiological effect of deep flushing, but had no influence over the convulsions. Then I administered chloroform, stopping the convulsions whilst the child was under the influence of the anæsthetic; but they returned on discontinuing it. Eight p.m., temperature 107.2° F.; administered an enema, producing a natural action of the bow-

els, and then gave an injection of a scruple of hydrate of chloral. Nine p.m., convulsions uninterrupted, temperature, 110° F. On the suggestion of Dr. Tilson—in consultation with me—put the child into a bath at 75° F., and cooled it down with blocks of ice to 40° F., temperature reduced to 101° F. Before putting it into the baths the convulsions had gone from the right to the left side, after the administration of the chloroform. Eleven p.m., temperature 105° F., rising steadily; fits uninterrupted; child sinking. Died 2.30 a.m., February 22d. Temperature, 108°; 3 a.m., 110°; 6 a.m., 103°. At this hour, the mother—who lived in the country—took the child home. I should add that all the temperatures were taken in the axilla. The child, as far as the mother knew, was in perfect health previously to the seizure; had eaten a good meal of bread and mutton broth at one o'clock, and had had a natural evacuation after its dinner.

I was not able to get a post mortem, but the evidence seemed to me to point to insolation, from running bare-headed into powerful Australian summer sunshine.—*Provinc. Med. Jour.*, June 1, 1887.

Aitkin (D. W.) on Foreign Bodies in the Alimentary Canal.—A child, aged five years was brought to me with the statement that she had just swallowed a large lead button, or rather weight, such as ladies put at the corners of their dresses to make them hang well. Although cross-questioned, the child gave an intelligent account of the incident; and so while I expressed my doubt as to the truth of the statement (the body being so large), yet I advised the parent to administer large pieces of dry bread, almost no fluid, and to watch the stools. To my astonishment the mother brought the lead to me, and stated that it had passed a few days after. No symptoms had declared themselves, except a little pain a few days before the evacuations. This was probably at the time of passage through the pylorus. This mass of lead measures 2.5 centimetres in diameter, is 4 millimetres thick, and weighs 19.65 grammes, that is, practically three-quarters of an ounce.—*Br. Med. Jour.*, June 11, 1887.

Brown (O.) on Whooping-Cough in a Cat.—For the past few weeks I have had under my care a little boy suffering from a more than usually severe attack of whooping-cough, and his mother informs

me that for quite a fortnight their cat has had five or six distinct fits of coughing daily, similar in every respect to the boy's, which end after the expectoration of frothy mucus. The cat between the attacks is tolerably bright and active though not so lively as she formerly was, and has considerably fallen away in condition. This is the first instance of a domestic animal becoming affected through, apparently, infection from a human being which I can remember having observed, and it occurred to me that the fact may be of interest to others.—*Br. Med. Jour.*, May 7, 1887.

A Convenient Vehicle for Cocaine.

—Dr. Bignon, of Lima, has recently advocated a solution of cocaine in liquid vaseline or petro-vaseline. It will dissolve as much as two per cent. of the drug, and the solution had the great advantage of not being liable to decomposition. It is said to be very active as a local anæsthetic, and to produce a more extended zone of diminished sensation. Less doses can thus be used and the risk minimized of undesirable symptoms, due to the occasional toxic effect of the drug. It is very useful in ophthalmic practice, a single drop being sufficient to dull sensation, and its action is rapid.—*Med. Press*, June 15, 1887.

Poisoning by Chlorate of Potash.

—Dr. Willie, of Halle, lately observed a case of poisoning by chlorate of potassium. The patient had taken 50 grammes of the drug daily for a month. The following were the symptoms: vomiting, profuse diarrhoea, dyspnoea, weak action of the heart, and cyanosis. The color of the blood became like chocolate. In the milder cases of poisoning by chlorate of potassium, gastro-intestinal phenomena are exhibited, with vomiting and congestion of the liver and spleen. Abdominal pains are complained of, and there is loss of appetite. The urine is diminished in quantity, and contains albumen; delirium, coma, tonic and clonic spasms, and unconsciousness sometimes supervene. Death occasionally takes place when the patient's condition appears to be improving.—*Br. Med. Journal*, June 4, 1887.

Morris (A. L.) on Obstructed Urethra.—About 4 P.M., a few hours after a normal delivery, I was hurriedly summoned by the lady's husband with the intelligence that the baby could n't "make water." The little fellow's penis seemed to be in a

constant state of priapism. I examined it closely and found to my astonishment that the meatus urinarius was completely closed. Taking a small pair of scissors which I carried, I clipped the obstructing membrane, still no "water." I then took a flexible probe, bent it as nearly in the shape of a catheter as I could, and introduced it into the child's urethra, being very careful lest I rupture the tender mucous membrane of my delicate little patient, at the same time using warm applications, and to my relief and his also, he "made water," after which I heard no more complaint.—*So. Pract.*, May, 1887.

Electricity and Lactation.—Pierron and Aubert record cases of suspended lactation in which a copious secretion of milk was brought about by faradization of the breast. One used simple sponge electrodes, the other a hollow hemisphere of protected copper which accurately fitted the breast.—*Rev. de Thérap.*, April, 1887.

BOOK NOTICE.

Earth as a Topical Application in Surgery.

By ADDINELL HEWSON, M.D., Philadelphia.
The Medical Register Company.

This work is an exposition of the use of earth in all cases requiring topical applications admitted in the men's and women's surgical wards of the Pennsylvania Hospital, during a period of six months in 1869.

The present is the second edition, but the author says it differs in no respect from the first, issued in 1872, and is interesting as describing what has been done in wound treatment rather than what is being done largely at present.

The first 187 pages contain a detailed account of ninety-three cases treated with the earth, which was from deep diggings well dried (but not roasted), and sifted through a fine flour sieve, the yellow subsoil common everywhere in our city [Philadelphia], rich in ferruginous clay, and entirely free of all sand, grit, or foreign matter."

Among these cases are many chronic ulcers, several burns and scalds, and a number of compound fractures, two wounds of the knee-joint, one a lacerated wound followed by pyæmia and death on the twentieth day. The second, incised wound, was carefully closed and treated with the earth.

Extensive and offensive suppuration from the joint followed, with death on fourteenth day.

Two amputations of the breast healed primarily. One healed almost entirely, and in the ulcer left maggots developed, as occurred three times in one case of burns and also in a compound-fracture, all due to negligence.

The compound fractures of the lower extremity did poorly.

Pages 188 to 309 are devoted to "Comments on Cases" and "Earth in Surgery, its Modus Operandi."

PUBLISHERS' NOTICES.

Horsford's Acid Phosphate.—I have used Horsford's Acid Phosphate in my practice for the past eight or ten years, and have been much gratified with the results obtained from its use. In various forms of dyspepsia it reaches a class of cases that no other medicine seems to touch, and I have repeatedly seen patients where opiates were contra-indicated, obtain refreshing sleep and rest at night from a single dose at bedtime.

DR. W. S. LEONARD.

Hinsdale, N. H.

Crystalline Phosphate.—

Provident Chemical Works,

Gentlemen :—The Crystalline Phosphate is an excellent preparation ; I have had great satisfaction from its use and can highly recommend it. Very truly.

J. P. GEPPERT, M.D.

Cincinnati, Ohio,

Iron-Alum Mass.—I have prescribed the "Seven Springs Iron-Alum Mass" in many cases of scrofulous diathesis, and expect to prescribe it in many more, for I do not know of any remedy that would give better satisfaction. WM. WHITE, M.D.

Abingdon, Va.

Lactopeptine.—I have used *Lactopeptine* in seven cases of obstinate *Vomiting in Pregnancy* with perfect success in each case. V. H. MOORE, M.D., M.C.P.S., Ont.

Brockville, Ont., Canada.

Milk of Magnesia.—The Charles H. Phillips Chem. Co., 30 Platt St., New York, desire to call your attention to their ad. on front page of cover. Their Milk of Magnesia should be given a fair trial in the acid diarrhoea of Children, Cholera Infantum, Vomiting in Pregnancy, food souring on the stomach, or kindred ailments. It will be found a superior agent. Mention the MEDICAL ANALECTIC.

McArthur's Hypophosphites.—It will pay you to try McArthur's Syrup Hypophosphites Compound (chemically pure) in cases of Phthisis, Nervous Diseases, or Wasting Diseases of the System, and you will be well pleased with results. Report your experience with them to McArthur Hypophosphite Co., Boston, Mass., and mention the ANALECTIC. See ad.

Cherry Malt Phosphites.—To physicians not familiar with the merits of Cherry Malt Phosphites, The Liebig Phar-

macal Co., New York, will send a full-sized bottle *free*, if the physician will pay express charges, and mention the MEDICAL ANALECTIC.

Gurney Cottage.—Now is the time to send your patients to the country. The above cottage, situated at Atlantic City, N. J., offers special inducements to physicians. See ad.

Lactated Food.—G. W. Hatch, M.D., 305 West 22d street, New York City, writes: "I have used Lactated Food in a case in which the stomach was intolerant of all food. Lactated Food was retained and assimilated, and not only nourished the patient, but overcame the condition of indigestion as well. Within three or four months, or the period of time since this preparation came to my notice, I have used more than twenty-five pounds of it. This fact is sufficient to show that the Lactated Food is, in my hands, productive of results highly satisfactory."

Home for Inebriates.—Send to the Superintendent at Fort Hamilton (L. I.) N. Y., for information in regards to accommodations, etc., for patients addicted to alcoholism, and the opium habit.

Murdock's Liquid Food.—Send for sample, circulars, etc., to the Murdock Liquid Food Co., Boston, Mass., mentioning this journal

Aletris Cordial.—I have used Aletris Cordial (Rio) with the happiest results, in an aggravated case of Prolapsus Uteri and Leucorrhœa of three and a half years' standing. The patient is now using the second bottle, and it has given her more relief than any other medicine before prescribed. I am so favorably impressed with it that I shall prescribe it in all cases to which it is adapted in the future. S. MONG, M.D.

Cincinnati, O.

Home for Nervous Diseases.—Send to the director of this home, "Kensett on the Sound," for catalogue, etc., and mention the ANALECTIC.

Invalid Reclining Chairs.—The chairs made by the New Haven Folding Chair Co. are without doubt the best on the market ; if you desire one, see ad. on another page for address, etc.

Hydrolene.—For information in regard to this successful preparation, send to the agents. See ad. on second page.

THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

VOL. IV., No. 8.

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WHOLE No. 44.

LEADING ARTICLES.

On the Treatment of Stricture of the Urethra.—In a paper read before the Medical Society of the State of New York,¹ Prof. Otis emphasized the importance of determining the exact seat of the stricture or strictures, before an operation is done or dilatation is commenced. This can be ascertained by using the urethrometer, or *bougie-à-boule*, and by their use the author found that in one thousand cases critically examined, less than ten per cent. were located at a point beyond four inches from the urethral orifice.

It is thus seen that if dilatation is practised without locating the depth of the stricture, in the great majority of cases the dilating instrument would be passed beyond the stricture, unnecessarily irritating the membranous and prostatic portions of the urethra where the greatest dangers of gradual dilatation reside.

In cases where the chief symptom of stricture is difficulty in urination, and only small flexible instruments can be passed, the fact is often overlooked that, while there is obstruction in the deeper urethra, this may be due to spasmodic contractions of the membranous portion brought about by the presence of organic strictures nearer the meatus. If these anterior strictures are discovered and removed, a full-sized sound may be made to pass with ease into the bladder, as the author has proved in several cases.

"It will sometimes occur that strictures may be traversed by filiform instruments, and can be located by very delicate bulbous instruments, but where the calibre of the stricture is too small to admit the smallest guide bougie of the urethrotome of Maisonneuve. In such cases, where

immediate operation has become necessary, the only resource is an external urethrotomy. For aid under such conditions, I have had constructed, and have frequently used with much satisfaction, a miniature Maisonneuve, of scarcely more than half the size of the ordinary instrument, carrying a blade of not more than three or four millimetres' breadth. This, with due care, may readily pass a stricture where no other cutting instrument can, and subsequently the ordinary-sized urethrotome of Maisonneuve may be readily entered.

"This little instrument in my hands has, in repeated instances, saved the patient an external urethrotomy, when without it such an operation would have been unavoidable."

Permanence of results after operations on deep strictures depends, as in the case of anterior strictures, upon completeness of division. Complete sundering at some point is essential to radical cure.

It has been proved to be essential to the cure of deep strictures to cut *all* anterior strictures, and the writer quotes Sir Henry Thompson as saying that if one stricture is cut all should be likewise divided.

Dr. J. W. S. Gouley, in an article in *The Medical Register*² protests against the indiscriminate cutting of the meatus to enable large sized instruments to be passed through deep-seated strictures, believing that over-distension does more harm than good.

In cases of prostatic obstruction to urination, if the meatus is small it is proper to incise it enough to admit freely catheters of proper size.

So, too, in chronic gonorrhœa in the balanic region, if the meatus is small it should be incised to allow the introduction of sounds. But the doctrine that the meatus

¹ *New York Med. Jour.*, Feb. 19, 1887.

² February 12, 1887.

should be the largest part of the urethra, the author says, is not only unsound, but most dangerous.

In a discussion following the reading of a paper on internal urethrotomy by Mr. Buckston Browne,¹ Mr. Lockwood stated that after dividing strictures in the anterior part of the urethra he had found that deeper complicating strictures often disappeared as stated by Otis. Mr. Browne did not believe "in a penile stricture causing a spasmodic stricture lower down."

The author gives in his paper ten classes of cases in which he would perform internal urethrotomy, among which are cases in which time is an object, when the stricture is near the meatus, when the passage of sounds causes rigors and prostration, in dense and resilient strictures, in cases where a stricture and urethral fistula co-exist, in cases where a perineal abscess and stricture co-exist.

Dr. S. W. Gross in a discussion following a paper read by Dr. Brinton on the treatment of urethral stricture, said²:

"Formerly I was a rather firm believer in the treatment of stricture by divulsion. I do not employ this method now, although I would use it in a case of retention of urine. It is no more dangerous than cutting, and cutting is no more dangerous than divulsion. The cutting can be more accurately limited than the divulsion. With the latter method we tear not only the stricture but also the mucous membrane at some distance in front of and behind the stricture. In a specimen in my possession where divulsion was employed, there were no less than nine rents in the mucous membrane; and the rent in the stricture was oblique and had not gone completely through the stricture. This method will do in superficial strictures, but in hard fibrous strictures we have to supplement this operation for urethrotomy. It is for this reason that I have given up divulsion for internal urethrotomy, and I do not resort to this latter operation so frequently as I formerly did. When the patient is within convenient distance, I much prefer in ordinary cases of inflammatory stricture, and in recent cases more particularly, to resort to gradual dilatation. I have reached the firm conviction that the cases in which radical cure is produced by divulsion, in-

ternal incision, or external incision, are so rare that it is rarely worth while to resort to these operations."

On the other hand Prof. Otis in the *North Carolina Medical Journal* for March,³ says:

"Nothing is more distinctly laid down in the writings of authorities in regard to the urethral stricture than that the results of dilatation are always of a temporary character. It is therefore well understood in the cases of cure of gleet by dilatation of the stricture or strictures upon which it is dependent, that subsequent dilatation must be kept up, *indefinitely*, at varying intervals, in order that the gleet may not be reestablished.

"For a permanent cure a complete division of the stricture or strictures must be had, and any treatment which falls short of this will, of necessity, fail in doing more than to temporarily remove the obstruction which has been the cause of the gleet. It is, however, desirable that a temporizing course should be pursued in many cases, for various reasons.

"In some cases there will be want of time and means; in some lack of the instruments, skill, and experience necessary to a radical cure of the stricture. In a very large proportion of cases the prejudice against any cutting operation will be the sole objection, and this is encouraged by the advocates of dilatation who refuse to accept the well-authenticated evidences of prompt, satisfactory, and complete cure of stricture and of the gleet through complete division, and who persistently ignore the possible perils of its continuance. These also underrate the dangers of dilatation, while exaggerating the risks and discomforts of dilating urethrotomy. For such and perhaps other reasons, the treatment by gradual dilatation will be required in many cases."

Otis prefers the solid nickle-plated sound for dilatation and gives directions for its proper performance, concluding as follows:

"In many cases, in which I explore the urethra, I do not pass the instrument *into the bladder*, for the reason that stricture is very seldom situated near the bladder. I cannot be too emphatic in warning you to keep out of your patient's bladder. Do

¹ *British Med. Jour.*, Feb. 12, 1887.

² *Med. and Surg. Reporter*, Feb. 12, 1887.

³ From *Jour. Cutan. and Genito-Urinary Diseases*.

not enter it even for exploratory purposes, unless you think it absolutely necessary to do so. First explore the anterior urethra and relieve, as far as practicable, any abnormal condition that may exist there. Keep out of the bladder, if possible. It is the disposition of the profession all over the world, when exploring a urethra or dilating a stricture, to pass the instrument on into the bladder. Now, there is absolutely no danger in passing an instrument gently down to the membranous junction, but there is always danger in passing an instrument beyond that point on into the bladder. Death has occurred in more than one instance from suppression of urine through a reflex irritation, caused by gently passing a bougie into the bladder, where disease of the kidneys and bladder was present. I have known many cases of swelled testicle that occurred simply from the passage of a sound through the deep urethra, and at least one case where the loss of a testicle was directly due to introduction of bougies for dilatation of stricture, thus setting up an orchitis which finally ended in an abscess which destroyed that organ."

He advises in cases when the urethra is sensitive that five or ten grains of quinine be given one or two hours before passing the instrument, to lessen the tendency to urethral fever and, in sensitive cases, rest in bed following the operation.

Dr. Bangs' strongly urges early performance of external urethrotomy in minor traumatism of the urethra. He asserts that in recent cases, before pathological changes have taken place, the operation is not a difficult one although in old cases where there is cicatricial tissue it may be difficult of performance.

In the discussion following the reading of Dr. Bang's paper. Drs. Otis, Keyes, and McBurney agreed with the author that where an injury to the perineum was followed by swelling or signs of inflammation or difficulty in passing both large and small sized sounds to the bladder, external urethrotomy should be at once performed.

GEO. B. PHELPS.

Bond (F. F.) on Cannabis Indica in Diarrhoea.—Rennie, in the *Indian Medical Gazette* for December, 1886, calls attention to the value of Cannabis Indica in the treatment of dysentery. We wish

to draw attention to its value in a similar condition, namely diarrhoea; especially in the type known as summer diarrhoea. Attention was drawn to it in this connection by Turner, in the *Lancet* (vol. ii., 1866, p. 536). He says, "In ordinary diarrhoea, the formula in a modified dose, will

℞ Tincturæ cannabis indicæ . . .	℥x
Spiritus chloroformi . . .	℥x
Tincturæ kino . . .	3j
Aquam menthæ piperitæ ad . .	3j

be found very serviceable. Being connected with a dispensary where thirty or forty cases of diarrhoea presented themselves daily for treatment during the months of August and September, and where a great variety of remedies were tried, so great was the superiority of Indian hemp above the others, that the patients themselves got to know it, and invariably asked for the green medicine."

We have been in the habit of prescribing it in nearly all forms of diarrhoea with marked benefit, combined with medium doses of morphine. In summer diarrhoea the effects are very striking. There is no necessity to record cases; they are all very much alike; the great depression, the frequent watery stools, the vomiting and the cramp-like pains are very quickly relieved, the appetite speedily returns, and by the following or third day the cases are practically well, except for some weakness and debility. The formula we generally use for an ordinary adult is:

℞ Tincturæ cannabis indicæ . . .	℥x
Liquoris morphinæ . . .	℥v vel ℥x
Spiritus ammoniæ aromatici . . .	℥xx
Spiritus chloroformi . . .	℥xx
Aquam ad . . .	3j

To be repeated every 1, 2, or 3 hours according to circumstances. Directions: *No food for several hours, but a little brandy and water.* We have not seen one case run on to a fatal issue under this treatment.

It appears to act by increasing the astringent and anodyne properties of the morphine (the dose of morphine would have very little effect alone), by its stimulant effect on the nervous system, improving the tone, and by improving the appetite; thus enabling the system to quickly overcome the marked depression and exhaustion. Most remedies in this disease rather retard the return of the digestive functions, but from our experience Indian hemp markedly accelerates it. Indian hemp seems also to frequently counteract the bilious action of

morphine, as well as the loss of appetite, and allows it to be given where it otherwise would not be tolerated.

In other forms of gastro-intestinal disturbance it is also valuable, probably for the same reasons. It was of marked use in a case of subacute gastro-enteritis, which had existed for a few weeks before it came under our care, in a girl aged 13 year, showing the following symptoms: marked anæmia, which had gradually come on after the other symptoms; constant pain over the abdomen, especially in the epigastric region, increased on pressure and after food; tongue covered with yellowish-white fur; loss of appetite; vomiting at variable times after food of partly digested material; diarrhœa, six or eight stools in the day, which were watery and green, containing partly digested food-material; some rise in temperature—a little over 100° F. She was first treated with bismuth, then with effervescing mixtures, with no benefit; then with the cannabis mixture (modified to suit her age), and the symptoms very quickly subsided, the vomiting and diarrhœa were checked, the pain ceased, and the appetite returned. By the end of the week all the symptoms had disappeared, except the anæmia, which persisted for a short time longer.

In cases of tuberculous diarrhœa we have not seem much benefit, beyond a slight relief of symptoms for a short time, though we have not had sufficient experience in this type; nor in the excessive diarrhœa in typhoid fever.—*Practitioner*, July, 1887.

Lee (H.) on the Use of the Actual Cautery in Surgical Operations.—Before the introduction of anæsthetics in surgical operations the use of the actual cautery was justly regarded as a barbarous and cruel practice. The traditions of one age descend to the next, and the application of a hot iron to the body is thought of by the public, and even by some members of our profession, as a thing not to be tolerated in scientific surgery. All objections to the use of the actual cautery, however, vanish as soon as it can be said that it gives no pain. We may therefore now fairly consider its advantages as compared with other modes of arresting hæmorrhage.

Since the year 1853 I have been in the habit of sealing bleeding vessels with the actual cautery in all kinds of operations. Amputation of the thigh was performed in one case with excellent result, a single ligature being placed on the femoral artery.

In three cases of amputation of the leg the actual cautery alone was used.

The application of the cautery coagulates the albumen in the blood, and in the tissues to which it is applied, and if used at a proper temperature the parts will adhere firmly to the iron and to each other. The heat will also coagulate the blood in the vessels. A very superficial layer (if any) of the parts to which the cautery is applied is actually killed, and any part so killed is charred, so as to become not readily liable to septic decomposition.

The actual cautery has the great advantage of closing the veins as well as the arteries, and inasmuch as the great dangers in surgical operations arise from the absorption of septic agents through unclosed veins, it obviates one of the surgeon's greatest anxieties. The ligature of a vein, as is well known, is not free from risk, and the obvious reason is that during the time the ligature is separating a certain amount of suppuration necessarily takes place, and the products of that action may give rise to septic absorption. The same dangers, although to a much less degree, obtain, when an artery is tied in its continuity. In one case the current of blood is towards the centre of the circulation, and in the other from it. When mischief arises from the cause mentioned after ligature of an artery in its continuity, the results are manifest in the peripheral circulation, and not in the central organs. It is not improbable that gangrene of an extremity after the ligature of the principal artery of a limb may arise more often from the circulation of vitiated blood than from want of blood. Simple want of blood is indicated by paleness of the skin. In the majority of cases of gangrene the skin contains far more blood than usual, and is of a dark brown color.

It is quite possible, as experience has but too often proved, that a septic action commenced around a ligatured artery may be communicated to surrounding parts, and from these septic absorption may take place. This, in fact, is one of the most fruitful sources of pyæmia.

The actual cautery may be applied sometimes where a ligature cannot be; as, for instance, in wounds of the deep palmar arch; and, on the other hand, a tenaculum will sometimes reach a vessel to which the actual cautery cannot be applied. In one case where a very large tumor was removed from his back, the vessels were all sealed

by the actual cautery, except one, which bled persistently. The reason of this became immediately apparent. The projecting posterior edge of the scapula prevented the cautery from coming fairly into contact with the bleeding vessel, I have now used the actual cautery in a great variety of operations, and during the last thirty-five years in a large number of cases of hemorrhoidal tumors, and have as yet had no case of purulent absorption. Recently I assisted in removing a cancerous growth from the inner canthus of the eye. The bleeding was free and general. The surface was touched with the cautery, and the bleeding immediately ceased. The patient, next day, said he felt more comfortable than he had done for a long time previously.

I prefer the common iron cautery to the benzoline knife, if no dissection has to be made. The oxide of iron appears to exercise a direct influence in producing coagulation of the blood. Many years ago, when engaged in some physiological researches, I received some blood from a horse that was being bled into an old iron vessel, coated on its inside with the red oxide of iron, and was surprised to find that the whole mass of blood became immediately coagulated. Another minor advantage of the cautery is that it can be applied much more quickly than the ligature. Where many vessels have to be dealt with at the same time, this is by no means unimportant.

Practically, it is difficult not to use the cautery too hot. If it kills the parts to which it is applied the intended result is not produced. A good test of the amount of heat required may be obtained by dabbing the cautery on a wet sponge until very little steam is produced. In cases where it is important that no oozing of blood should take place after the application of the cautery, it is well to allow it to remain in contact with the divided vessels for about fifteen seconds.

Where the actual cautery can be fairly applied it has proved, as far as my experience goes, the best antiseptic.—*Medical Press*, June 15, 1887.

Mays (T. J.) on the External Treatment of Pulmonary Consumption.—We have, in the majority of instances in this disease, a condition which is a deposit of inflammatory products in the lung, differing essentially in nowise from a similar deposit in any other part of the body; and it is very natural to suppose

that that which does good in the one condition will also be useful in the other. You know as well as I can tell you that the application of moist heat and of passive motion are of inestimable value in producing reabsorption of chronic inflammatory deposits in joints and in other parts of the body—usually the result of injury; and in keeping with this idea, I have for a number of years been in the habit of applying hot flaxseed-meal poultices, as well as friction, to the chest in such affections, and I believe with the most gratifying results. According to my view these external applications have the power of increasing the circulatory, the lymphatic, and the cellular activity of the circumference of the infiltrated lung tissue, and, by their operation on the surroundings of the diseased centre, they gradually reduce and remove the consolidation.

The flaxseed meal is boiled and spread three-quarters of an inch thick between two pieces of flannel cut in the shape of a jacket, which is well fitted to the top, front, and back of apex, as well as to the anterior and posterior aspects of the affected lung. It is then adjusted to the chest, and the outside well covered with oiled silk or oiled muslin. It must be changed every two or three hours, or sooner if it becomes cool. If it is made properly, it will remain warm for three hours. This process is to be continued from morning until night, when the poultice is taken off, and the chest is well wrapped with woollen flannel for the night, in order to avoid a sudden disturbance of bodily temperature during the sleeping hours. The next morning the same programme is begun, and it is continued in the same way for at least three weeks, or as much longer as is necessary. It is much more expedient to poultice during the day only, and allow the patient to rest during the night. After the patient has been poulticed for five or eight days a change in the physical signs begins to manifest itself. Where previously there was heard nothing but a roughened or bronchial breathing, subcrepitation, probably crepitation, and mucous râles show themselves, leading one to suspect that the disease is advancing instead of improving. Subsequent experience teaches, however, that these superadded signs are due to the process of resolution which is taking place. The patient experiences greater freedom in breathing, his cough becomes easier, and

his expectoration is looser, and at the end of the prescribed time there is usually an improvement in his general condition.

In addition to the application of moist heat, I very frequently employ local or general massage once or twice a day. This has undoubtedly the power of assisting the former method in removing the intra-alveolar material.

This external plan of treating pulmonary consumption and other chronic inflammatory diseases of the chest I have had under trial for nearly half a score of years, and it is not only of great practical importance on account of its efficiency, but also on account of the economy which can be practised in regard to giving medicine by the stomach. The digestive organs always deserve great consideration in the treatment of chest diseases, and the less they are utilized for administering medicines, and the more for the purpose of feeding the patient, the greater will the benefits be which accrue to the latter.—*Med. and Surg. Reporter*, July 9, 1887.

Laryngeal Papilloma.—In *Lezione Bollettino*, Anno v., No. 2, Massei gives the history of a case of papilloma occurring in a girl of thirteen, who had complained of hoarseness for one year. Laryngoscopic examination disclosed a little elevation, pale-red and movable, situated on the anterior third of the left vocal cord. The rest of the cavity was normal, except that the cords, slightly swollen and reddened from the presence of the tumor, could not approximate during phonation. The author prefers excision to cauterization. In general one should avoid irritating the growth. In the case in question tracheotomy was performed. (The reason for this operation is not apparent. The author seems to share the popular delusion that benign growths within the larynx show an especial tendency to assume malignancy, a fallacy which has been exposed by Semon and Butlin in the *Brit. Med. Four.*, June 4, 1887.)—*Four. of Laryngol. and Rhinol.*, June, 1887.

An editorial in the *Phila. Med. News*, June 25, 1887, relates to intra-laryngeal papilloma and epithelioma. The writer observes that differential diagnosis is generally not difficult. Occasionally neither the laryngoscope nor the microscope gives positive evidence. In papilloma there is no submucous infiltration; the lesion is a hyperplastic outgrowth formed in the pro-

cess of repair of an erosion or an ulcer, or in the course of a simple prolonged inflammation. It grows by division of the papillæ, and its base is therefore smaller than its free portion in some parts. Those cases in which several independent neoplasms coalesce most strikingly resemble epithelioma. In general, given a clinical history of hoarseness and dyspnoea following a laryngitis, a sessile warty growth in the larynx having a relatively narrow base, with or without congestion or inflammatory swelling of surrounding mucous membrane, may be regarded as papilloma, in the absence of histological evidence to the contrary. In the early stages of epithelioma the distinctive points are more obvious, but later on, at the period when the patient usually comes under laryngoscopic observation, when, as is often the case, the lesion becomes obscured by a papillomatous overgrowth, differentiation is much more difficult, especially in an apparently healthy subject. Now, too, microscopic examination may not be entirely reliable, since only the papillomatous outgrowth may be removed by means of laryngeal forceps. An instructive instance in the communication by Semon, referred to above, illustrates the possible contingency of epithelioma and simple inflammatory tissue in a way which might have led to serious confusion.

The possibility of transformation of a benign into a malignant growth is suggested, and the very great importance of recognizing the proper time at which to discontinue irritating local measures and to resort to more radical interference is especially urged.

Intralaryngeal epithelioma remains confined to the inner portion of the tube for a long while before extending beyond its borders or through its walls; and consequently, if the general health of the patient does not suffer in the interval, a serious operation like that of excision of the larynx, unilateral or bilateral as may be, may well await positive demonstration that the deeper seated portions of a doubtful growth are more malignant in character than any inflammatory growths or outgrowths which may have been removed. Even then, too, it may be possible to cut away the respiratory walls infiltrated with the neoplasm, and thus save the wings of the thyroid cartilage with their important attachments of the muscles of deglutition; an operation involv-

ing far less immediate risk to life than excision of the whole of the laryngeal skeleton ; and which, theoretically at least, should be equally efficacious in ridding a patient of disease limited to the interior of his larynx.

In cases of undoubted papilloma so extensive or so located as to preclude eradication through the mouth, or exhibiting uncontrollable recurrence, it is far better to divide the larynx externally and to operate efficiently in the direct manner, than to continue to tear away little fragments at a time, indefinitely, to little purpose.—(See *N. Y. Med. Jour.*, June 18, 1887, "Description of a Modified Laryngectomy," by J. Solis-Cohen.) CHAS. H. KNIGHT.

Adams (Wm.) on the Treatment of Congenital Displacement—the so-called Congenital Dislocation—of the Hip-Joint by Long-Continued Recumbency and Extension.—The chief points in the pathological and clinical history which appear to be established are :

1. That in all specimens of this so-called congenital dislocation of the hip, the head of the femur, although displaced upwards, has been found to be still within the capsular ligament, so that no true dislocation exists.

2. That in every dissection the acetabulum has been found to be deficient as far as regards the osseous rim and cotyloid ligament, which essentially forms the deep cup-like cavity. This can only be regarded as a congenital malformation, since the floor of the acetabulum is well formed.

3. That the head of the femur is always diminished in size, and somewhat flattened and irregular in outline, but covered with a thin layer of healthy articular cartilage. The round ligament is sometimes present and elongated, but in many cases is absent.

4. That the capsular ligament becomes elongated, and greatly increased in thickness and density.

5. That in consequence of the absence of the acetabulum, the head of the femur gradually ascends on the dorsum ilii under the influence of the weight of the body after the walking period. There is no evidence that the head of the femur is ever displaced by muscular action.

6. That the gluteal muscles, being thrown out of action from the absence of the natural ball-and-socket articulation and alteration in their natural direction, gradually pass into a state of fatty degeneration.

7. The consecutive deformities, involving the pelvis and the spine, which occur

in these cases, if allowed to pursue their course without any treatment being adopted, are severe and important, more especially when occurring in females.

8. The theory of this affection being a traumatic dislocation, produced by the accoucheur, is negated by the pathological condition found on dissection, and the collected series of sixty cases which have occurred in my own practice, and which I published in my previous paper [On the so-called Congenital Dislocation of the Hip-Joint, *Brit. Me. Jour.*, Nov. 7, 1885].

Treatment.—It is necessary to be borne in mind that the shortened limb can be elongated without pain by gentle extension, and the great trochanter will descend one or two inches ; but, as soon as the extension is removed, the shortening returns.

It has been reserved for Dr. Buckminster Brown, of Boston, to carry out the treatment by recumbency and extension more thoroughly, with greater attention to details, and for a longer period than has hitherto been done, and his efforts have been rewarded by the most marked success.

Instead of keeping the child confined to bed, and in the house, I have recently employed a new extension couch. The child is placed on a movable plane, covered by a mattress, and the straps for extension and counter-extension are attached to the plane, the extension being made by a check-pulley, instead of a weight and pulley. On this plane the child can be lifted from the couch and carried about the house, or taken into the open air on a spinal carriage, whilst the extension is being maintained.—*Brit. Med. Jour.*, April 23, 1887. JOHN RIDLON.

Jackson (H.) on Myositis Universalis Acuta Infectiosa, with a Case.—I saw last spring in Strassburg the following rare case,¹ and though I had hoped to

¹ Since I read the report of this case before the Section for Clinical Medicine, Pathology, and Hygiene, of the Massachusetts Medical Society, the case has been published in full in the *Berliner Klinischer Wochenschrift* for April 25, 1887. Prof. Kussmaul gives the disease the name of "Pseudo-Trichinose ; eine besondere Form von Acuter parenchymatöser Poliomyositis." Contrary to my statement Prof. v. Recklinghausen reports hyaline degeneration of the muscles, but no fatty or granular degeneration. I see no advantage in the name "pseudo-trichinose," as the disease has nothing to do with trichinosis, and I should much prefer the name "Acute Infectious Universal Myositis," as first given by Kussmaul in his clinical lecture on the case, and again applied by me in my paper upon the same case, as mentioned above.

be able to give a more detailed account of the case, think that the few notes taken at the time, may be of interest to the members of the society. The above diagnosis, made by elimination during life, by Prof. Kussmaul, was sustained by the result of the autopsy performed by Prof. von Recklinghausen. The case entered the hospital May 18th, and was demonstrated in the clinic May 22d.

Woman, aged thirty-six ; family history good ; she has two healthy children ; lives in a district apparently healthy ; no one else sick in the house. Was never sick before so far as she knows.

Six weeks ago first felt sick. Malaise, inability to work ; had a red papular eruption on the face, pain in the neck, pain in swallowing. She was treated for a sore throat. The eruption disappeared in a week's time without special treatment.

After the disappearance of the eruption, first noticed swelling, accompanied by pain in the shoulders, legs, and sacral regions ; the swelling in legs soon passed off, appearing in arms. Last two weeks pain in the neck, swelling less marked. The pain, which was at first sharp, has become dull. Pain has always been in the muscles and not in the joints. Throughout the sickness appetite fair, thirst marked, sweating, moderate fever, constipation, no vomiting, urine scanty and high-colored.

On entrance, May 10th, slight fever, mind clear, slight œdema of face and extremities, muscles of extremities flexed and rigid ; extension caused pain. Paresis of soft palate, electrical reaction in general diminished, reflexes absent. Examination of chest and abdomen negative.

During last few days high fever, rapid respiration, pulse 140. Several small patches of pneumonia.

Prof. Kussmaul considered the diminished electrical reaction as due, in part, at least, to the œdema, the abolition of the reflexes as of peripheral, not central origin ; he considered the pneumonia as very probably due to particles of food which got into the lung on account of the difficulty in swallowing. Mind clear to the last ; no symptoms pointing to disease of the abdominal organs. Death on May 24th ; ultimate cause, broncho-pneumonia.

Trichinosis was first thought of ; eliminated by the history (her husband did not allow her to eat raw sausages), by the absence of the gastro-intestinal symptoms as

prodromata in this disease, by the fever in present case. Prof. Kussmaul said the case reminded him clinically of one in which thousands of miliary aneurisms were found all over the body.

The fever, the widespread muscular pain and œdema pointed to a diffused myositis without any discoverable local cause, hence the diagnosis was as stated.

Autopsy, May 25th. Brain and spinal cord presented nothing abnormal. Veins of abdominal cavity very full of blood. Spleen soft, enlarged. Stomach and intestines presented nothing abnormal.

Stricture at the entrance of the pelvis of right kidney into the ureter, which had caused hydronephrosis of right kidney with almost total disappearance of the substance of the right kidney. Left kidney much enlarged, otherwise not abnormal. Heart pale.

In both lungs several small patches of pneumonia. The muscles, throughout the body especially in the extremities, the trunk and the face (orbicularis) pale in color and moist ; many small hemorrhages in sheaths of the muscles ; rupture of left rectus abdominis, with hemorrhage.

Under the microscope muscles showed waxy and granular degeneration ; fibres broken ; small cell infiltration in the interstitial tissue, in no place amounting to the formation of abscesses visible to the naked eye. Nuclei of the muscles increased markedly, showing a real proliferation of muscular tissue, as well as a degeneration.

I heard no report of the bacteriological examination, but, reasoning by analogy with diseases which have been studied, we may say that bacteria were most probably associated with the inflammation.

Prof. von Recklinghausen told me that when he was an assistant of Virchow's, he had seen two similar cases, but I have been unable to find a report of them.

We have here some acute disease of a febrile nature, rapidly ending in death. At the autopsy a widespread myositis is found, otherwise no pathological lesions which can be considered as a primary cause of the severe symptoms existing during life.

Dr. Blodgett kindly called my attention to a similar case published lately in the *British Medical Transactions* (Dec. 18, 1886, p. 1215). Acute myositis, (Mr. Treves.)

After exposure to severe cold, the following symptoms were manifested : chill, malaise, fever, loss of power in arms, cramp-

like pain. Similar pains in legs. Gradual recovery in six weeks. Mr. Treves divides myositis into: (1) Simple, due to injury. (2) Myositis from cold. (3) Infectious boil or osteo-myelitis. (4) Attending various infectious diseases. (5) Trichinæ.

This is the only case I find in the recent medical journals, German or English. In the fourth volume of *Virchow's Archives* (1852), is an article by Virchow on myositis. Anatomically, he divides myositis into: (a) Interstitial; (b) Parenchymatous; (c) A combination of (a) and (b). Etiologically divided into: (a) Traumatic; (b) So-called muscular rheumatism; (c) Syphilitic; (d) Septic. Then he goes on to say: (e) "One finally sees abscesses occur in muscles under conditions as yet not made out, under conditions spoken of by the Vienna school as 'spontaneous pyæmia.' General symptoms are chill, high fever, disturbance of heart, severe, widespread pain; death in few days. Such processes may be of spontaneous origin, more commonly due to other septic diseases, especially typhoid."

A similar allusion I find in Förster. In Lobstein a case of death where the only lesion was a myositis (general?) and local patches of pneumonia.

In none of the more recent works on pathology do I find any mention of a myositis, widespread in area and independent of some preëxisting centre of infection.—*Bost. Med. and Surg. Jour.*, May 26, 1887.

Hemopericardium.—Two cases of hemopericardium have been recently reported in the *London Lancet*. J. W. Batterham reports the following case.¹

On March 9, 1887, I was called to a lady who had died suddenly. She was seventy-five years old, and had suffered for "some time" from "slight fits," in which she "struggled" and lost consciousness for a few minutes. These fits were usually preceded by sickness. About noon on the day of her death she complained of pain in the left mammary region, and took a Gregory's powder. She then had lunch, which consisted only of a little beef-tea. Her servant coming into the room about an hour after lunch found her sitting in a chair dead. The deceased's face was pallid. She appeared to have vomited just before death, as some brownish fluid containing

gritty particles (apparently the beef-tea and Gregory's powder) was seen staining her chin and the front of her dress.

The necropsy, performed twenty-four hours after death, showed the heart enveloped in about four or five ounces of dark clot. There was no rupture of the heart or great vessels. On the posterior surface of the heart was a slight subpericardial ecchymosis, covering an area about the size of half-a-crown, situated on the interventricular groove about an inch from the apex of the heart. A fine aperture with ragged edges was discovered in the pericardium covering the centre of this ecchymosis. On vertical section through this aperture, a few small clots were seen in the muscular substance of the hypertrophied left ventricle. The largest was about the size of a small pea, and was situated immediately beneath the minute aperture in the pericardium above described. The coronary arteries were tortuous and thickened, their coats containing numerous calcareous plates. On dissecting out these vessels, the left, after running down the anterior interventricular groove and turning round the apex to the back of the heart, was found to terminate in two main offsets, which surrounded the area of hemorrhage. Two small twigs were traced into the clots, but were of too small size for any rupture of their walls to be detected. These, I imagine, were the chief source of the hemorrhage. The heart weighed 12½ oz. Its muscular tissue was firm and of good color. The thickness of the right ventricular wall was one eighth of an inch, that of the left (at its thickest part), half an inch. The valves were normal in appearance; the aorta was healthy. The other thoracic and the abdominal viscera were normal, with the exception of the kidneys, which were small, red, and granular, and showed a marked diminution in the cortical substance. The head was not opened.

From the post-mortem appearances, it may, I think, be concluded that the "fits" from which the deceased had suffered were probably of uræmic origin. The pain in the chest felt for a few hours before death may have been due to the rupture of fine branches of the left coronary artery into the myocardium, while the perforation of the pericardium and subsequent hemorrhage into the pericardial sac, resulting in fatal syncope, may have been induced by an act of retching.

¹ Notes on a case of hæmopericardium from ruptured coronary artery, *Lancet*, June 4, 1887.

Hemopericardium is not a very uncommon condition. References to between eighty and ninety cases may be found in the first thirty-five volumes of the Pathological Society's Transactions. The most frequent causes are rupture of the heart or aorta, occasionally from violence, but more commonly the result of disease. Seven cases due to rupture of an aneurism of a coronary artery are referred to in vol. xxii. of the Transactions. Scurvy has also given rise to hemorrhage into the pericardial cavity. On reference to Neale's "Digest," I find that a case of hemopericardium arising from a ruptured coronary artery is narrated in the *Medical Times and Gazette* for 1862 (vol. i., p. 317). In this instance the patient, a woman aged sixty, lived six days after the appearance of the symptoms, of which præcordial pain, dyspnœa, a small, frequent, but regular pulse, and coldness of the extremities appear to have been the chief. A case of purulent pericarditis in which a rupture of a coronary artery was found is quoted in Ranking's Abstract for 1861 (vol. ii., p. 85).

Mr. Arnold Evans reports¹ a case of hemopericardium caused by rupture of an aneurism of the coronary artery. J. D—, aged five, was admitted on Jan. 29th, 1887. He was a pale, emaciated, and feeble child, with scarcely sufficient strength to walk; he had three small unhealthy-looking sores, two on the face and one on the leg. His father, who brought him, said that for three weeks the child had suffered intensely from thirst and copious diuresis, the former being so distressing that he would even drink dirty water from puddle-holes in the road. Enormous quantities of urine were passed after admission, and a specimen examined was pale and clear; it had a specific gravity of 1002, and contained neither sugar nor albumen. The thoracic organs were examined, but nothing abnormal detected. When attempting to sit up in bed on the morning of Feb. 1st he complained of pain in the chest, then fell back and died almost instantaneously.

At the post-mortem examination the pericardium was distended with about five ounces of clotted blood, adherent to the walls of the heart. The ventricles were contracted and empty; valves competent and health. On removing the clots, a softened spot, surrounded by ecchymosis,

was discovered in that part of the wall of the left ventricle which is overlapped by the appendix of the left auricle, the auricular appendix itself being discolored externally, but its external surface quite healthy. A probe passed along the left coronary artery from the aorta appeared at this softened point, and on dissecting out the artery it was found that its lumen at the above-mentioned point was increased and its walls attenuated, the aneurismal dilatation thus formed being about the size of a pea. It was clearly from a rupture of this aneurism that the hemorrhage had occurred.

Although hemorrhage into the pericardium is of frequent occurrence from a variety of causes, it rarely happens that rupture of an aneurism of the coronary artery occasions it. I have been able to find records of nine similar cases, a *résumé* of most of which by Dr. Crisp will be found in the twenty-second volume of the Transactions of the Pathological Society; in most of these cases, however, the subjects had reached an advanced age, and the chief interest of the case just recorded is centred in the age of the patient.

THERAPEUTICS.

Dubois (R.) and Roux (L.) on the Action of Chloride of Ethylene upon the Cornea.—Bouchard has recently recognized and described the peculiar changes in the crystalline lens (cataract) which follow the administration of naphthaline.

The authors, in studying the anæsthetic action of the chloride of ethylene upon dogs, noticed that the cornea remained transparent during the inhalation and during the subsequent elimination of the drug, but that in sixteen to eighteen hours, sometimes later, the two corneas began to lose their transparency, taking on an opalescent, bluish tint, which gave a strange look to the animal. The inhaler was so constructed and applied as to allow no direct access of the vapor to the eyes.

Exaggerated tension of the globe was noticed, which attained its maximum at the time of the appearance of the corneal opacity, and it remained in diminished degree for fifteen days until the animal was killed. The convexity of the cornea was much increased, particularly in the vertical meridian, giving the appearance of a total

¹ *Lancet*, July 9, 1887.

anterior staphyloma, opaque and symmetrical in both eyes.

Impaired vision was preserved, and with a bright light it was possible to decide that the lens remained clear, but it was impossible to make out the details of the fundus. Oculo-pupillary and palpebral reflexes were preserved, as was the sensibility of the cornea and retina.

The authors are undecided whether the increased intraocular tension or the dehydrating effect of the drug produces the corneal opacity.—*La France Méd.*, July 5, 1887.

Grandclément on the Principal Indications for Eserine.—The author employs eserine in all cases where the ocular tension is either increased or diminished. He thinks it acts on the eye as digitalis upon the heart, regulating the circulation in the eye and the secretion and excretion of intraocular liquids.—*La France Méd.*, June 21, 1887.

Hare (H. A.) on the Use of Antifebrin in Epilepsy.¹—The favorable results which have been obtained in the treatment of epilepsy in France by Dujardin-Beaumetz, and in this country by several well-known observers, led me to test its efficacy in several cases of severe and intractable epileptic cases; and while absolute cures were not effected in any of them, a very marked decrease occurred both in the number and severity of the seizures. Briefly, the cases may be stated as follows:

Case 1. *Æt.* thirty-five, male; has had epileptic attacks ever since childhood, and cannot remember when the first attack came on, probably very early in his life. His attacks have become more frequent and severe within the last two or three years, until at the time he first came under my observation some ten months ago he was having as many as six or eight attacks a week. At that time he was placed on bromide of potash in the dose of fifteen grains three times a day, and though this treatment was kept up almost continuously until last March, no improvement of any moment showed itself. The fits had, indeed, increased in frequency, and matters had come to such a pass that he could not work, owing to their frequent occurrence. About March 15th I began giving him five grains of antifebrin three times a day in powder, and at the end of the week he re-

ported that he had used all the powders, and had had but two paroxysms. The following week he escaped with two very light attacks, with scarcely loss of consciousness, from his description. Since then he has had on the average only one a week, and once or twice has missed even that. He has now been taking the drug about eight weeks, and, although not by any means cured, is certainly much relieved.

Case 2. *Æt.* eighteen, male, was brought to me by his father, a man of a very inferior order of cerebral development, who stated that his son had suffered with fits from childhood; and the condition of the boy confirmed the father's words, for he had degenerated into that form of drivelling mental imbecility which so frequently overtakes those cases of epilepsy which arise in early youth. He suffered from as many as three to five seizures a day, and in one instance had evidently been in that condition known as the *status epilepticus* for as long as twenty-four hours. I gave this case also five grains of antifebrin three times a day, and although I had the opportunity to see him only once again in the course of a week, the father related that his fits were not so frequent, being one or two less than they had been for a week or so before.

The third case is perhaps the most interesting of the three, since it occurred in the person of a nurse-maid, *æt.* 35, with whose history I had been conversant for the last twelve or thirteen years, and of whose manner of life and attacks I can speak more positively. Four years ago she began to suffer from attacks which so closely resemble *petit-mal*, according to her description, that there can be no doubt of their nature; and these seizures increased in severity and frequency till about eighteen months ago, when she suffered from her first true epileptic seizure during the night, waking the family by her scream previous to the advent of the convulsive movements.

She was unconscious, and fell into a deep sleep, in which she remained till late in the morning. After this time the attacks gradually became more frequent, and although the true epileptic seizures rarely exceeded one a month, the periods in which she suffered from *petit-mal* became much more frequent and prolonged. The convulsions also occurred in the day-time as well as night. Bromide of potash in ordinary doses did not seem to control them, nor did the

¹ See MEDICAL ANALECTIC, 1887, p. 300.

administration of the iodide salts, for the purpose of retarding the growth of any brain tumor, produce any change other than indigestion, and the other signs showing that the iodide was not well borne, thus eliminating any chance of specific taint, of which, however, there had never been any suspicion. There was no family history of epilepsy, except in the person of a first cousin, and the case seemed to belong to that class known as "idiopathic epilepsy," which not rarely occurs previous to the 35th year.

When placed upon antifebrin she had had as many as two attacks a month instead of one, with almost daily minor seizures. Antifebrin was now begun in the same dose as in the other cases, and though this was over two months ago, no return of the true paroxysm has appeared, and the number of lesser attacks has been reduced to as few as one or less a week.—*Med. and Surg. Reporter*, June 11, 1887.

Suckling (C. W.) on Antipyrine as an Anodyne in Locomotor Ataxy.—I have tried antipyrine in three cases of locomotor ataxy, in which the pains were severe, with relief in each instance; in one case with complete abeyance.

A man, aged 48, in an advanced stage of locomotor ataxy, applied to me for relief on account of severe shooting pains in the legs, of almost daily recurrence. I gave him antipyrine in ten-grain powders, one to be taken in water when the pains came on. After taking two powders the pain ceased, and he was free from them for a week, when they returned, to be again checked by a powder. He stated that he had not been so well for twelve months, having been continually in pain.

I think that antipyrine will be found to be of great use in the treatment of these hitherto intractable pains.—*Br. Med. Jour.*, June 11, 1887.

Anderson (A. B.) on Antipyrine in Puerperal Fever.—Mrs. P., aged twenty-six; married five years; first pregnancy; was confined on the 16th of January, 1887, attended by Dr. C. I was called on the 21st; patient had had a chill previous night; found her as follows: dorsal decubitus, great tenderness over lower part of abdomen, especially in right iliac region, temperature 104° , pulse weak and frequent, countenance pale and anxious, complaint of difficulty in breathing. Examination showed no trouble with the lungs. Diagnosis: Puerperal fever.

Gave opium for pain, quinia and digitalis for the pyrexia, and hot fomentations for the bowels. 22d, found patient feeling somewhat better, pulse stronger, countenance brighter, temperature 103° . 23d, patient worse, temperature 104° , pulse 130 and weak, difficult breathing, excessive tenderness over lower part of abdomen, no general peritonitis. Vaginal douches of hot carbolyzed water were ordered previous day, but not very well carried out. Lochia virtually stopped, vagina hot and dry. Gave to-day 5 grs. quinia with five drops tinc. ferri chloride, every four hours, with digitalis and whisky alternated. January 24th, patient slightly better, temperature 103° , pulse 96, and feels more comfortable, unable to pass water; use the catheter and continue former treatment. Was called again in the night; attendants thought the patient dying. She had evidently had a chill, which was followed by high fever and oppressed breathing. 25th, continued treatment. 26th, same treatment continued. 27th, patient so disgusted with quinia in the various forms in which I had administered it that she refuses to have any more of it; also refuses milk and whisky; changed to 10 grs. of quinia dissolved in hydrochloric acid every six hours, giving some grape wine instead of the whisky. 28th, had a prolonged chill from 5 to 8 P.M.; temperature 104° at 6 o'clock, and patient complaining of being cold; 10 grs. of quinia were given at 6 P.M., dissolved in hydrochloric acid; vaginal discharge purulent and offensive; catheter used twice daily, and turpentine stupes to abdomen. 29th, same condition and no particular change in the treatment. 30th, no chill to-day, but higher temperature (105°), great depression, pulse 120, and weak. 31st, no change, temperature 104° , countenance anxious, watches every move I make, evidently trying to read my prognosis; temperature has not been under 104° at any time during the last three days. Patient has had 10 grs. of quinia every six hours during that time. Somewhat cinchonized. Determined to drop the quinia, as it had utterly failed to control the high temperature. Gave 10 grs. of antipyrine at 1 P.M., and waited its action. At 2 P.M. temperature was down to 102° , and patient feeling better. I directed the nurse to repeat the dose at 6 P.M., if the temperature was not below 102° ; left also sol. ferri nitrate to be given in 5-gr. doses every three hours. Feb. 1st,

found the patient feeling much better, is stronger and has taken some nourishment with relish; temperature 102° ; nurse says temperature was down below 100° all night and rested well. I ordered 5 grs. antipyrine, and repeated at intervals of four or six hours to keep the temperature at or below 100° . Feb. 2d, patient still better, temperature $100\frac{1}{2}^{\circ}$ at 4 P.M., pulse 96, skin moist, has relish for food, takes butter-milk and gruel; has taken three 5-gr. doses of antipyrine in the last twelve hours; has had no quinia in forty-eight hours, and has had no chill. Kidneys act naturally to-day; some pain; bowels move well every other day by enema. 3d, patient doing well every way.

Was called in the night to use catheter. Drew $\frac{1}{2}$ pint of rather highly-colored urine. Prescribed nitre, tr. iron, and nux vomica; temperature $98\frac{1}{2}^{\circ}$, pulse 96. From this time the patient made a rapid and uninterrupted recovery.

This, with a number of other cases, has proven to my mind that in antipyrine we have an invaluable remedy in puerperal fever. Say what you may about removing the cause of disease, experience plainly teaches that we must attack the symptoms. In a great many of these cases the fever stands as a barrier before us in our attacks upon the disease. And when we control this condition, we save the powers of the patient to resist and meet other complications that may arise. When Dr. Thomas would use the rubber coil, I would use antipyrine. Dr. Fordyce Barker recommends when quinia fails to control the pyrexia, to use Warburg's Tincture. I would say, when quinia fails, and it generally will fail in puerperal cases, give antipyrine. If you give it as a specific you will be disappointed, but if you give in moderate doses to bring down the fever, to moisten the skin, to act on the kidneys, to increase the secretions of the mouth, you will not be disappointed, or your experience will not accord with mine.—*Peoria Med. Mo.*, June, 1887.

See (G.) on Antipyrine in Angina Pectoris.—According to See, antipyrine acts well in pain of almost all kinds, gr. xv., doses at intervals of half an hour, being able to suppress an ordinary attack of migraine. In the different varieties of cardiac pain, such as that caused by aortic insufficiency, aortitis, myocarditis, etc., its action is very satisfactory, and in angina

pectoris it gives equally favorable results. It is given continuously, as it does not act quickly enough to abort an individual attack. It has not the disadvantages inherent to the continued administration of the bromides, digitalis, or chloral.—*Four. de Méd. et de Chir. Prat.*, June, 1887.

Clermont (A.) on the Therapeutic use of the Neutral Hydrochlorate of Quinine.—The basic hydrochlorate of quinine requires twenty-two times its weight of water to dissolve it, while the neutral hydrochlorate will dissolve in its own weight of water.

It is prepared as follows: He dissolves in distilled water one equivalent (548 grams) of the neutral sulphate of quinine, and in another quantity of distilled water two equivalents (208 grams) of the chloride of barium, and mixes the two solutions. When the sulphate of barium settles the clear solution is decanted and evaporated at a temperature of 100° C.

The solid residue thus obtained is the neutral hydrochlorate of quinine. Its solution should be a pure bitter, but devoid of caustic taste.—*La France Méd.*, June 21, 1887.

Beard (R. O.) on Rest as a Factor in the Treatment of Trichinosis.—A mother and two young children were the victims of the disease.

The muscles of the extremities, and particularly those of so-called coarse fibre, were the first to be attacked.

The acme of the disease occurred when the diaphragm and other respiratory muscles were invaded, and the respiratory function was thereby interfered with.

The recorded exacerbations in each instance were marked by the implication of muscles previously uninvolved.

The most careful scrutiny of the contents of the alimentary canal, after or at the same time of each relapse, failed to produce any evidence of the presence of parent trichinæ, or of the evolution of a new generation of their offspring.

Full doses of alcohol, ammonia, quinine, and glycerine, sponge-bathing and nutritious food constituted the main treatment from first to last. Perfect rest was enjoined upon the patients. On the first day mercurial purgatives were given to the mother and son, but withheld from the younger child on account of her apparent exhaustion and the existence of a slight diarrhœa.

Each relapse was preceded by an imprudent infraction of the rule of rest.

It seems to me to be a well-sustained conclusion that the aggravated relapses noted in these cases, and so often observed in the course of this disease, are not, as is commonly supposed, due to the birth of new generations of trichinæ in the intestinal track and to their subsequent invasion of the muscular system, but are rather caused by the migration of the parasites from muscles already affected to others which have previously escaped their attack, or are less favorably situated for their chosen habitat.

Excessive restlessness or any indulgence in muscular exercise, is, I believe, often responsible for this disturbance of the trichinæ from the abode they have primarily selected, and for their re-emigration to other muscular areas. If these observations be well taken, the conclusion I have reached has a large measure of practical importance. Rest is the *sine qua non* of treatment is trichinosis. All authorities agree that the safety of the patient is subserved by the speedy encystment of the trichinæ in the muscular tissue. Any thing, therefore, which hinders the attainment of that desirable end and causes the parasite to "swarm," as it were, in search of other opportunities of undisturbed abode, is prejudicial to recovery. This fact suggests the wisdom of confining the patient to a condition of absolute recumbency in bed, and of using suitable sedatives for the control of undue restlessness and nervous excitement.—*N. W. Lancet*, June 15, 1887.

Gley on the Physiological Action of Inée.—This substance is employed by the Pahorins of Central Africa as an arrow poison. By Carville and Polaillon it has been considered a pure muscular poison; but experiments by the author convince him that it acts directly upon the cord.

The active principle is a glucocide, probably strophantine.—*La Trib. Méd.*, June 5, 1887.

Yount (S. T.) on the Use of Indigo as an Emmenagogue.—The doctor has used indigo as an emmenagogue for a year and a half. Its emmenagogue action was suggested to him by discovering that a female patient of his habitually employed it to produce abortion. He says it is odorless and tasteless, and may be given in from 3 i. to 3 iv. doses two or three times a

day. The crude drug produces nausea and vomiting in very large doses. He says: "It should not be given to pregnant women. It should not be given where there is an irritable stomach. It should not be given in cases where there is a history of a previous pelvic inflammation. It should not be given in cases where there is marked cerebral anæmia. Five grain doses of the concentrated extract may be given in place of the crude drug. The powder of the crude should be given mixed with a little subnitrate of bismuth, and the patient should drink a little whisky afterward. In cases where given continuously for a long period give tr. gentian comp. after each dose. Give the concentrated extract in capsules, mixed with extract of gentian and subnitrate of bismuth."—*N. Y. Med. Record*, July 9, 1887.

Schwartz (N. F.) on Boracic Acid in the Treatment of Leucorrhœa.—My manner of using it is as follows: Having first irrigated the vagina with water at as high a temperature as can well be borne by patient, a cylindrical speculum is introduced, and the vaginal walls very carefully dried—first, with a soft sponge, and then with absorbent cotton. This done, boracic acid in crystals is poured into the mouth of the speculum, and pushed up against the uterus and vault of the vagina with a clean cork caught in a uterine sponge-carrier, sufficient acid being used to surround and bury the intravaginal portion of cervix, filling the upper part of vagina. A tampon of absorbent cotton is then firmly pressed against the packing, and held *in situ* until the folds of the vaginal walls close over it as the speculum is withdrawn.

This should be allowed to remain three or four days, or even longer, as after this time there still remain some undissolved particles of the acid, nor will the tampon seem at all offensive. The ostium vaginae, if examined in twenty-four hours, instead of being besmeared with the leucorrhœal secretion or discharge, presents a clean appearance, and bathed in a watery fluid which begins to appear several hours after the packing has been placed, and in my cases this was the only discharge noticed afterward.

However, a second, or even a third, repetition may be necessary; but in none of my cases, numbering nearly a score, have I found more than a second packing called

for, and, in many, one sufficed; and in no instance has its use occasioned pain, not even inconvenience.

I do not claim for this agent and method infallibility, nor should constitutional dyscrasias be ignored and this local treatment be depended on unaided to effect a cure; but here, as in the treatment of leucorrhœa by other remedies, a proper association of all means having a curative influence upon the disease constitutes the rational therapeutics.

My individual experience with this remedy in the treatment of leucorrhœa, though limited to too few cases to establish its universal efficacy, if such a wide range of power can be claimed for any medicine at any time, none the less proves it as one of the agents which, when properly employed, promises much in the treatment of the annoying and sometimes intractable conditions constituting the pathology of leucorrhœa, particularly when the change is in the vaginal glands or mucous membrane, or from intra-cervical inflammation.

Nor will harm likely result from its use though it fail in maintaining the place my experience would give it.—*St. Louis Cour. of Med.*, June, 1887.

Besnier (E.) on the Treatment of some Cutaneous Affections.—The power of salicylic acid to make the skin desquamate suggested its utility in the treatment of pityriasis versicolor, and the author advises bathing the part with tar soap and then applying the following ointment.

Salicylic acid	3 parts.
Precipitated sulphur	10 "
Lanoline and vaseline of each	50 "

This ointment is rubbed in each night and washed off in the morning. Eight days treatment generally suffices.

In psoriasis of the scalp the doctor orders for two or three days, a rubbing in of a mixture of vaseline and lanoline. Then the scalp is washed with yolk of egg and water and after this with soap-suds or a decoction of Panama wood. The hair is rinsed out with hot-water and dried. After this cleansing process applications are made each evening with a five-per-cent. pomade of pyrogallic acid by means of a small brush. Every two or three days the head should be thoroughly washed.

To prevent the erythema apt to follow the application of mercurial ointment for pediculi pubis the doctor has the part

thoroughly washed and then powdered. He prefers a five-per-cent. pomade of calomel. A mixture of:

Oil of laurel	1 part.
Balsam of Peru	15 parts.
Petroleum	15 "

he has applied in some cases with a brush and then has the parts washed at the expiration of three hours.

Immersion of the part, for three quarters of an hour, in a bath of ~~sublimate~~ sublimate solution or local applications of a one-per-cent. solution of sublimate in spirits of peppermint kills the parasite but does not impair the vitality of the eggs. Bathing the parts with vinegar dissolves the chitine that holds the eggs to the hair and they can then be removed by a fine-tooth comb.

In the facial acne of old people which tends to turn into epithelioma he softens and removes the crusts by oil or soap and touches the ulcerated surface underneath with the actual cautery. When the ulceration is extensive he disinfects the surface with an antiseptic fluid and orders a permanent dressing of chlorate of potash solution, giving internally the same time xv. grs. of the same drug daily.—*Four. de Med. et de Chir. Prat.*, June, 1887.

Crittenden (W. J.) on the Use of Biborate of Ammonium in Uric Acid Calculi.—In patients who have attacks of renal colic every day, I prescribe twenty-grain doses of ammonium biborate every two hours until a free passage of urine takes place; then every four hours until all ill-feeling passes away; then I decrease to fifteen grain doses three times a day before meals in a glass of flaxseed tea, and so continue for several months—discontinuing it for a day or two at a time every two weeks. In cases in which the paroxysms recur once a week, I pursue the same plan of treatment.

If these paroxysms recur once a month, I give fifteen grains before each meal for two or three months at a time.—*Virg. Med. Mo.*, June, 1887.

Frazer (T. R.) on Dyspnœa, Especially on the Dyspnœa of Asthma and Bronchitis, and the Effects of the Nitrites upon it.—I have not obtained any facts that would justify the preference of any one of the nitrites because it possesses therapeutic advantages over the others in the treatment of asthma or bronchitis. There are, however, conveniences of administration which lead me to

give a preference to nitrite of sodium and to nitro-glycerine. They are both extremely stable, and they can readily be given in solution, either by the stomach or by subcutaneous injection. These advantages are not possessed by nitrite of amyl and nitrite of ethyl, and even the latter substance in the alcoholic solution of the *spiritus atheris nitrosi* of the Pharmacopœia is notoriously a very uncertain preparation. It is probable that the favor with which this preparation is, notwithstanding, regarded, is due not only to the action on the circulation which it shares with the other nitrites, but also to its previously unrecognized influence on dyspnœa, which is no doubt exerted when it is administered, as it so frequently is, in the treatment of bronchial catarrh. When the volatile nitrites are given by inhalation the effects are only of brief duration, but when they are given by the stomach the effects are similar in their relatively prolonged duration to those of the non-volatile nitrites. Nitrite of amyl, nitrite of ethyl, nitrite of sodium, and nitro-glycerine have each proved successful in my observations in relieving the dyspnœa of asthma and bronchitis. I believe they do so, by removing bronchial spasm, and the remarkable power which they possess in doing this will probably lead to their being more largely used than they hitherto have been in the treatment of disease. Where their administration is successful in removing the auscultatory evidences of such spasm, it is difficult to imagine any thing more convincing of the beneficial influence than can be exerted upon the conditions of disease by pharmacological agents. The observer has presented to him a patient in whose thorax a continuous succession of varying sounds is heard. Within a few minutes after a nitrite has been administered, the endless succession of noisy breath accompaniments gives place to an almost complete silence, in which only the subdued quiet of normal respiration is heard, and at the same time, what to us is of even greater interest and importance, the distress of dyspnœa, or, it may be, the intense suffering and anxiety of orthopnœa, is entirely removed.—*Lancet*, July 9, 1887.

Lange (J. C.) on the Use of Expectorants in the Pulmonary Diseases.—Are the depressing and spoliative effects of expectorants desirable, let us ask, in phthisis? An answer is obviously un-

necessary. Yet what is more common than to administer some cough mixture containing an expectorant, during the course of this affection? It is expedient, a matter of course, routine. An indication exists for, and the patient demands, some remedy addressed directly to the cough; the time-honored expectorant is chosen; its putative expectorant effects is of such importance that its perturbing and spoliative effects are forgotten or ignored.

Equally injudicious is this treatment when employed in chronic bronchitis. An affection which frequently entails upon the patient a dilated heart, and the pathological changes of which depend largely upon blood stasis, contra-indicates the exhibition of every agent which numbers among its effects a sedation of the heart and a diminution of nutritive supplies. The consequences of such a remedy, though they may be long endured, and though they may be difficult to measure, are certain to follow its administration: they are debilities which in and of themselves may be effectual bars to a recovery. Yet more pernicious is this treatment when employed in the pneumonia of old age, which disease is frequently a process of chronicity. As a disease imperatively requiring, above all else, most energetic supporting treatment, one in which all depressing measures are clearly contra-indicated, its proper management debars the use of the expectorants; and if these remedies enter into its treatment this therapeutics deserves the title which its result confers upon it.

The exhibition of the expectorants in the acute pulmonary diseases which are without danger to life, can be objected to only on the grounds that their expectorant action is observed to not follow their administration, that their revulsive action is too feeble to be of service, and that as nauseants, the worst they accomplish is to increase somewhat the patient's discomfort and debility. If our therapeutic resources do not embrace a better treatment for the cough of an acute simple bronchitis, for instance, then no more potent objections than those cited may be made to the administration of expectorants, perhaps; and yet it is conceivable how, particularly in the young, the old, and the feeble, this treatment may be a causative factor in the extension of a bronchial inflammation which terminates in catarrhal pneumonia. It is conceivable how the depressing effects of expectorants may consti-

tute the essential, because the necessary, factor, which induces an extension and prevents a resolution of inflammation; how these effects may constitute the metaphorical feather which breaks the camel's back. If this be true, it is a grave objection to this treatment which must be added to the trivial ones.

In another class of acute pulmonary diseases, namely, those in which danger to life is by apnoea only, the trivial objections to the employment of expectorants can alone be urged, provided this treatment is not allowed to displace proper and more energetic measures. In such affections we are not concerned with asthenia; we know the patient to be safe as far as exhaustion is concerned; hence no grave objection to the use of the expectorants exists, and the trivial ones are only to be remembered. These objections become potent, however, in all acute pulmonary diseases in which the danger is from asthenia. That is to say in other words, in all such diseases in which, if they end fatally, death is caused by the exhaustion of the patient. A class of diseases of which Dr. Flint has said, "The ending is a question to be decided by the tolerance of the patient; if this tolerance hold out, the ending is in recovery; if it do not, the ending is in death." This class embraces the majority of cases of acute pulmonary diseases, and their proper treatment presents this pre-eminent indication, to strengthen and to lengthen the tolerance of the patient. If the tolerance of the patient hold out, the ending is in recovery; if it do not, the ending is in death. The tolerance of a patient is not strengthened and lengthened by the exhibition of the expectorants, but is, on the other hand, weakened and shortened by it; and, again, it is conceivable how this weakening and shortening, be it ever so limited and difficult to measure, may constitute that factor in a case which determines a fatal ending.—*Med. and Surg. Reporter*, July 16th, 1887.

Shattuck (F. C.) on some Hospital Cases of Phthisis: Marked Improvement under General Treatment, with Special Reference to Alimentation.—The cases reported had been treated in the Good Samaritan Hospital of Boston, which is devoted to the care of chronic disease. Many of the patients had been exposed to unfavorable hygienic surroundings. The treatment employed was devoted largely to improvement of the general condition.

Search had been made for a specific treatment. If the disease is of a parasitic nature, it is natural to suppose that such a treatment would be of avail. At present, no such method of treatment is known. There are few individuals to whose lungs, at one time or another, the bacillus does not gain access. The fact that certain individuals are affected, while others escape, forces us to believe that there is a predisposition to the disease. The treatment employed by the author had consisted in relieving symptoms, improving the digestion, and the administration of as much food as the patient could take in the natural way. Artificial feeding had not been resorted to, but the patient was fed six or seven times a day. From two or ten raw eggs with milk, were given daily to each patient. Alcoholic stimulants were not administered to these patients as a routine treatment, but were used only temporarily for special purposes. He had, for several years, been systematically cutting down the quantity of alcohol used in chronic cases, and had seen no reason to regret it. His experience had been that alcohol was not used with sufficient discrimination in chronic cases of diseases. Beef, milk, eggs, and other nourishing articles are more expensive than alcohol, but if they can be consumed in sufficient quantity, they are more useful. In 1883, the amount expended per patient for alcoholic liquors had been \$2.70, while in 1886, it had been only thirty-four cents. The patients received no injury, even if they were not benefited by this reduction. Eight cases of well-marked phthisis were reported, in which a decided gain in weight and general improvement resulted from the employment of the plan of treatment above described. About sixty cases had been under treatment.—*Bost. Med. and Surg. Four.*, June 16, 1887.

James (S. E.) on a Novel Remedy for Asthma.—A man had been a sufferer for years from paroxysms of asthma, and had tried various remedies with but little relief and no permanent good, and was in a condition to adopt any thing that would promise a good result. One of his fellow-workmen told him that if he would take a few bird-shot every day for a while he would get relief from his trouble, and without further questioning he purchased one half-pint (about four pounds) of No. 8 bird-shot, and proceeded to take a teaspoonful three times a day. He continued to do

this for three weeks before he found it necessary to send for a physician, though he had had colic almost every day since he began his novel treatment. Noticing the retracted condition of his abdomen and the offensive nature of his breath, Dr. James examined his gums, and discovered a well-marked blue line in both the upper and the lower jaw. Upon being asked if he had been where he could have contracted lead-poisoning, the patient confessed to having taken the shot. Constipation had existed almost from the time he began this treatment, though he had had an operation every two or three days. Careful examination showed that there was no peritonitis, and that the vermiform appendix had failed to imprison any of the shot. The first indication seemed to be to remove the cause of the trouble, and this was accomplished in part by the use of active purgatives supplemented by injections. The result of the first experiment was the removal of about one pound of the shot. The patient was then given iodide of potash and an anodyne, and allowed to rest a day or two, when the cathartics and injections were resumed and an additional pound of shot removed. The bowels were kept open, and the discharges examined carefully, but no more shot were passed, and the patient continued to improve under iodide of potash, and at the end of three weeks had entirely recovered from the lead-poisoning. Dr. James adds: "The case is of interest as showing to what great abuse the alimentary canal can be subjected and still suffer no permanent lesion. The vermiform appendix seemed to enjoy a particular immunity from danger. Iodide of potash was a prompt and efficient remedy in removing the lead from the system, as was proven by repeated examinations of the urine. The blue line was marked, as the patient was unaccustomed to the use of a tooth-brush or tooth-pick. The appetite was not materially interfered with, and, aside from the pain, the patient suffered very little damage. His breathing was free and easy, and no paroxysms of asthma occurred while the lead was being eliminated, though the disease asserted itself after he had recovered from the lead-poisoning. The relaxation of the system from pain and shock probably kept the asthma in abeyance.—*N. Y. Med. Record*, July 9, 1887.

Desplat on the Treatment of Ulcers of the Leg with the Salicylate

of Bismuth.—To simple and varicose ulcers of the leg the Doctor applies a 10 per cent. pomade of salicylate of bismuth and encases the limb in a water-glass bandage. If any discharge or odor becomes apparent, the bandage must be reapplied; if not, it can be left on for 3 to 4 weeks, and when taken off the sore is generally entirely healed.—*La Therap. Contemp.*, June 24, 1887.

Potter (S. A.) on Sepsis and Antisepsis in Summer Diarrhœa.—The main positions advocated in the study of summer diarrhœa are:

1. That micro-organisms bear an important casual relation to a large proportion of cases of summer diarrhœa.

2. That antisepsis of the digestive tract is an essential element in the treatment of the disease.

3. That in antisepsis must be included not only the use of drugs, but also the establishment of all conditions known to be unfavorable to the life and activity of micro-organisms.

4. That in order to a more scientific use of antisepsis, we require more accurate information as to what organisms are concerned in the production of fermentation, their life-history, and the conditions favorable and unfavorable to their growth.—*N. Y. Med. Record*, July 9, 1887.

Shuford (O. A.) on the Treatment of Internal Hæmorrhoids by Injection.—For small tumors I inject from three to five drops and for larger ones from five to eight drops of the following mixture: Rub well together one drachm of salicylic acid and one and one-half drachm of glycerine, and add two drachms of carbolic acid; then rub together one drachm of borax and one and one-half drachm of glycerine, and mix the two thoroughly, allowing the mixture to stand until clear. The chemical changes and the *modus operandi* of this combination I do not know; but I do know that internal hæmorrhoids treated in this way become atrophied, shrink up, and peel off without pain, inflammation or suppuration. I have never had any trouble or heard any complaints from patients so treated. The two essential points in the treatment of internal hæmorrhoids are: first, an instrument that will bring the parts to be treated into view, and that without pain; and, second, a remedy that will completely destroy the pile, while leaving the mucous membrane in a healthy condition. An

interval of from eight to ten days should be allowed to elapse between the injections, so as to give the mucous membrane time to become toughened. The injections cause almost no pain, and do not prevent the patient from pursuing his ordinary avocations.—*N. Y. Med. Record*, June 25, 1887.

McMechan (J. C.) on a Case of Traumatic Tetanus Successfully Treated by Hypodermic Injections of Sulphate of Morphia.—The patient was growing worse, opisthotonus to a degree had set in, and the patient was fairly screaming with pain. The spasms came on at least every five minutes and thus far our remedies had failed to control the disease. As he would not take the chloral internally, and could not retain it when injected per rectum, I concluded to try the effects of morphia injected hypodermically. A quarter of a grain was injected; in two hours, as that had failed to quiet the spasms, half a grain was injected. In three hours this dose was repeated and the patient found considerable relief. At the consultation we concluded to abandon all other medication and give the morphia alone. After giving the morphia in half grain doses hypodermically four times a day, or in other words four times from 7 A.M. to 10 P.M., and giving one or two doses internally during the night, and continuing this treatment two days, it was found necessary to increase the amount to three quarters of a grain at each dose; and several times, as the patient was having such terrible spasms, as much as a grain was injected at a time. The effects of the subcutaneous injection was all that could be desired. The patient frequently slept an hour at a time, and the spasms were less frequent and not so severe. These large doses of morphia were given for eight days, subcutaneously, four times a day, and one or two doses were given internally during the night.

On August 1st the patient had improved so much that the injections were only given three times a day and in half grain doses. This treatment was continued until the 6th of August, when the dose of morphia was reduced to one quarter of a grain three times a day, and on the 9th the hypodermics were discontinued and quarter grain doses given internally every five hours. After another week the dose was reduced still more, and on August the 21st the patient was up and able to go about

and took no more morphia.—*Cincin. Lancet and Clin.*, July 9, 1887.

McChord (R. C.) on the Treatment of Four Cases of Acute Traumatic Tetanus.—The first case was treated with bromide of potash and chloroform, recovered. The second case with bromide of potash and chloroform, and although the mildest of the four cases, died—probably from neglect to keep up the administration of potash. The third case was treated with chloroform, bromide of potash, and chloral, recovered physically, but mentally a wreck; whether the latter was due to the potash, or chloral, or not, it is impossible to say. The fourth case was treated by amputation, bromide of potash, and chloral, with perfect recovery in every respect.—*Four. Am. Med. Ass'n*, July 16, 1887.

The Treatment of Agalactia.—No drug approaches the power of jaborandi in driving milk into the breasts. So certain is this action that we have been enabled by it to detect a fraudulent fluid extract, and to trace it back to a careless labeller at the manufactory.

But we have never been able to satisfy ourselves as to what cases really require jaborandi. In one case we thought we had a typical indication. The mother, a large, handsome woman, weighing over two hundred pounds, became fatter with every childbirth, but had scarcely any milk. It seemed obvious that if we could divert the nutritive current from the woman's system to the breasts, the increase of milk would also be accompanied by a disappearance of the useless and undesired fat. No milk had been present for over two weeks. We gave her ten drops of fluid extract of jaborandi, repeated every four hours. The milk soon made its reappearance, and for a time all went well.

But in a few weeks we were hastily called in, and found the mother had taken to her bed. She informed us she did not sleep, was indescribably nervous, and that she was possessed with such an insane desire to brain her family with the hatchet, that she begged us to have her put under restraint. We stopped the jaborandi, the milk ceased to be secreted, and as it disappeared the nervous phenomena did likewise.—*W. F. W. in Med. World*, July, 1887.

Morphinomania in Animals.—It would seem that animals are at times liable

to suffer from or contract the vicious habits of their owners, and an interesting communication was recently read before the French Institute bearing on this subject. In countries where opium smoking is common, it is by no means unusual to find that cats acquire a liking for the opiate vapors which they at first inhale with repugnance. The cat will jump on its master's bed as soon as the pipe is set going, and will voluntarily inhale the smoke. In other cases monkeys and dogs have exhibited similar tendencies. Animals so addicted are generally characterized by a melancholy and dejected mien, and they sleep more than is usual with animals of their species. A cat, the property of a gentleman in Cochin China, exhibited in a very marked degree the narcotic and exhilarant effects of opium. He became caressing and playful in a way quite foreign to his ordinary habits, and often appeared to be intensely happy. Two monkeys not only inhaled the smoke with evident delight, but acquired the habit of chewing the unconsumed opium. So pronounced was the morphine habit in these animals, that if the *stance* were delayed they would howl with anguish and roll upon the floor. Savage animals, such as panthers, have been admirably tamed by habituating them to the inhalation of opium smoke.—*Med. Press*, June 29, 1887.

Popular Remedies.—There are a number of medicinal agents in such general use, that many people try what they can do with them before applying to a medical man, not always with the desired result. Paregoric, spirits of nitre, and even laudanum, are instances of this class of remedies, to which cocaine seems likely to be added, unless a few more fatal cases put a check to the craze. None of these drugs, however, rejoice in the popularity which arnica has acquired for itself in the treatment of bruises and ecchymoses. Notwithstanding incontrovertible evidence of the effects attributed to it being really due to the alcoholic solvent, it is still the sovereign remedy for a threatening black eye or aggressive kick. Indeed, we find it mentioned by so great an authority as Dr. Lauder Brunton "internally and externally" for ecchymoses, in the last edition of his "Treatise on Therapeutics." If the result were only to credit arnica with properties which it has been shown not to possess, no great harm would have been done; but there is evidence to show that although

the plant is devoid of any resolvent effect on damaged tissues, it possesses irritant qualities which may, under certain circumstances, give rise to violent inflammation. It is more particularly when the tincture is applied to abraded or mucous surfaces, that these irritant effects are manifested, and many instances are on record of serious damage as a consequence of its unguarded application.—*Med. Press*, June 8, 1887.

ORTHOPÆDIC SURGERY.

ABSTRACTS AND SELECTIONS BY JOHN RIDLON, M.D.

The first annual meeting of the American Orthopædic Association was held in New York, June 15 and 16, 1887. The report in the *Medical Record* (N. Y.), June 25, 1887, gives short abstracts of the following papers:

Congenital Occlusion and Dilatation of Lymph-Channels, by Dr. George B. Packard, of Hartford, Conn.

Pott's Disease, with Unusual Deformity, by Dr. H. Ling Taylor, of New York.

A Case of Hip Disease, in which it was supposed that a very good recovery had taken place, by Dr. Bradford, of Boston, in behalf of Dr. Lovitt, of Boston.

Notes on Two Cases of Pott's Disease, Illustrating the Difficulty of Diagnosis in Very Young Children, by Dr. John Ridlon, of New York.

Osteoclasts, a report of fifteen cases, by Dr. Dillon Brown, of New York.

Kœnig's Operation of Lumbago and Iliac Incision for Iliac Abscess. A report of five cases, by Dr. Bradford, of Boston.

Torticollis from Defective Attachment of the Muscles of the Eye, by Dr. Bradford, of Boston.

Remarks were made on Excision of the Knee, by Dr. T. G. Morton, of Philadelphia, and on The Treatment of Psoas Abscess from Caries of the Spine, by Dr. Henry Hodgen, of St. Louis.

A patient, on whom he had performed division of the tendo-Achillis and plantar fascia in a case which had resisted mechanical treatment, was presented by Dr. Lewis Hall Sayre, of New York.

And two cases illustrating Osteitis of the Shoulder, were presented by Dr. V. P. Gibney, of New York.

The following apparatus was presented: An Ischiatic Crutch, by Dr. A. B. Jud-

son, of New York, a cut and full description of which may be found in the *Medical Record* (N. Y.), June 25, 1887, page 721.

A Plantar Spring for Flat Foot, by Dr. A. Sydney Roberts, of Philadelphia.

The Antero-Posterior Spinal Support, with Recent Modifications, by Dr. H. Ling Taylor, of New York.

A Device for Overcoming Intermittent Traction in Hip-Splint Apparatus, by Dr. Samuel Ketch, of New York.

An Apparatus for the Treatment of Round Shoulders, by Dr. Charles F. Stillman, of New York, and A Device for Preventing Adduction in Hip Disease, by G. S. Knickerbocker, of New York.

"The Connecting Link," a tail-like body removed from the side of the coccyx of a mulatto girl three years old, was presented by Dr. Gibney, of New York, in behalf of Dr. Ap. Morgan Vance, of Louisville, Ky.

The officers elected for the ensuing year were :

President—Newton M. Shaffer, of New York.

Vice-Presidents—E. H. Bradford, of Boston, and A. Sydney Roberts, of Philadelphia.

Secretary and Treasurer—Lewis Hall Sayre, of New York.

Corresponding Secretary—S. Ketch, of New York.

Poland (J.) on the Diagnosis of Traumatic Separation of the Epiphyses. The chief points in the diagnosis of these injuries were fully discussed. Special importance was attached to the particular period of age in which it occurred in particular bones. At this time the separation was found to be of a simple character and complete—that is, completely through the epiphysary line of cartilage. Above and below this age the detachment was frequently incomplete or partial, and often very complicated, defying the most skilled surgeon to give an accurate account of the precise anatomical condition of the lesion. Separation of the epiphyses without displacement was described as a most important practical point to be constantly borne in mind, otherwise a number of these injuries would be overlooked. Stripping up of the periosteum, and its subsequent inflammation, were found to take place in this, as well as in the case of complete separation, but to a much less extent. The question of prognosis, especially as regards the partial separation, was mentioned, as

well as the various dangers likely to be met with. Acute joint disease, as in the hip, was often the result of a separated epiphysis.—*London Lancet*, May 7, 1887.

Sinclair (T.) Report upon a Case of Cleft Sternum Exhibited by Dr. Scott.—The child is a female, and is now three months old. There is no other congenital defect but the imperfect sternum, the degree of the cleft in which is of rare extent, amounting to complete vertical division of the entire bone. The sternum is not absent, as at first appears, for a strip of cartilage binding the costal cartilages together, may be felt as the margin of the cleft on each side. The child appears more comfortable when the viscera are gently repressed and the cleft edges approximated by the use of a pad and a flannel roller. The various functions of the body are well performed.

Viewed in relation to the functions and mechanism of respiration, the case presents the following noteworthy points :

1. The first and second ribs are much more movable than usual, and the muscles attached to them and the clavicle are more frequently employed as inspiratory muscles, in short; the upper part of the thorax is of more than ordinary service in respiration in this child.

2. The movements of the ribs upwards in inspiration tend rather to open the cleft than to advance the representations of the sternum. In consequence, the lateral diameter of the chest is abnormally increased, while the antero-posterior diameter gains little or nothing by the elevation of the ribs.—*Dublin Four.*, June 17, 1887.

Jones (R.) Ankylosis, Hypertrophy, and Extreme Lateral Curvature of the Cervical and Upper Dorsal Vertebrae, Following Acute Rheumatism, Successfully Treated by Mechanical Means.—The patient, æt. eleven years, was received into Stanley Hospital, Liverpool, two and a half years after an attack of acute rheumatism affecting nearly every joint.

The deformity was very unusual. The angle of the right jaw rested on the sternoclavicular notch, the face looking almost parallel to the left shoulder. It suggested the appearance of extreme wry-neck. The muscles at the front of the neck were, on the contrary, atrophied from disuse. It was impossible to obtain even a remote sensation of yielding on trying to elevate

the side of the face. The right pupil was widely dilated, due to pressure on the sympathetic. The articulation was indistinct, and the respiration sometimes very hurried. The bodies of the cervical vertebræ were enormously hypertrophied, especially to the left side, and painful on pressure. The vertebræ were ankylosed as low as the fifth dorsal.

The treatment consisted in inserting paper wedges between the jaw and the sternum, followed by a Thomas' leather collar, and an iron framework for oblique traction on the deformity; and passive movements. —*Brit. Med. Jour.*, Feb. 5, 1887.

Homans (J.)—A Case of Contracted Fingers (Dupuytren's Contraction) successfully operated upon after the Method of Mr. Adams.—The patient was thirty-two years old, the conductor of a railway train. The contraction had been going on for nine years, until his little finger was flexed almost completely on the palm; his ring-finger was bent to a right angle, and his middle finger was somewhat bent. The operation was as follows:

A puncture was made between the transverse crease in the skin, and the annular ligament with a very fine tenotomy knife. This puncture should be made when the skin is not adherent to the fascia, nor tightly stretched, so that the knife can be readily introduced between the two. A cut was then made downwards, dividing the tight bands and digital prolongations that could be found. Several other similar punctures and cuttings were made in the same way, all as subcutaneously as possible. The punctures were then covered with corbolized absorbent cotton, and the fingers immediately straightened as much as possible, and bound to a moulded metallic splint. *Boston Med. and Surg. Jour.*, Feb. 24, 1887.

Poore (C. T.) on the Treatment of Inveterate Talipes Equino-Varus by Osteotomy.—The management of cases of congenital equino-varus which have resisted all the usual methods of mechanical treatment—tenotomy, stretching, etc.—has received much attention from surgeons, and various operations have been proposed for its correction. The majority of infants with this deformity are and can be cured by mechanical treatment, but there is a certain number of persons who, either from the marked degree of the deformity,

neglect, or inefficient treatment, are unable to walk on the plantar surface of their feet, and in whom locomotion is labored and painful. Even in children it is sometimes impossible to hold the foot in a proper position without the aid of apparatus, after years of careful treatment. With the brace applied they are able to walk on the plantar surface of their feet, but, as soon as it is removed, the anterior portion of the foot reverts to its abnormal position.

Through the kindness of Dr. J. B. Bisell I have had the opportunity to examine the bones taken from a child eight months of age who exhibited this deformity. Compared with the bones taken from a child of the same age with normal feet, the following are the points of difference:

The angle at which the neck of the astragalus is set upon its body in the bone from the deformed foot is 55° , while that of the normal bone is 28° . The external surface of the neck of the abnormal is much longer than that of the normal bone; the articulating surface of the head is much smaller in the former than in the latter.

The anterior articulating surface of the os calcis is directed forward and inward in the bone from the deformed foot, while in the normal it is directly forward. Its anterior portion is curved outward in the deformed foot, but is straight in the one from the normal foot.

In looking at a dissection of a foot affected with the deformity under consideration, the following points suggested themselves:

1. That the inability to correct the deformity was due to changes taking place in the astragalus and os calcis.

2. That, in order to bring the anterior portion of the foot into its normal position, the curvature in the os calcis must be removed and the neck of the astragalus shortened, so as to allow its head to point in the normal direction and thus carry with it the scaphoid and other tarsal bones.

To accomplish this, the following operation was performed: An incision was made from a point one inch and a half in front of the tendo Achillis on the outer aspect of the foot forward to the middle of the cuboid bone, and down to the tendons of the peroneus longus and brevis; these should be raised or pushed out of the way. Another incision, beginning from the middle of the first, and corresponding to the neck of the astragalus, was made di-

rectly upward; the tissues were then raised from the bones and the periosteum incised over that part of the os calcis from which it was desired to remove the wedge. With a chisel, a V-shaped piece of bone was taken away, base outward, and its apex extending to its inner border; a wedge was then removed from the neck of the astragalus of such a shape as to allow the anterior portion of the foot to be brought outward and upward. The periosteum was united with catgut and the skin with several wire sutures, because the latter held longer and gave better support. An aperture was left posteriorly for the insertion of a drainage tube; a plaster-of-Paris bandage was applied, extending from toes to above the knee, and the foot was placed in a correct position; the wound was dressed with iodoform and gauze. The size of the V-shaped interval left after removal of the wedge of bone should be sufficient to allow the anterior portion of the foot to be placed in proper position without any tension on the tissues on its inner aspect. The dressings should be as tight as possible, not bulky, otherwise it will be found difficult to apply the plaster-of-Paris bandage firmly. Three cases are reported.—*N. Y. Med. Jour.*, Jan. 15, 1887. J. R.

DISEASES OF THE NOSE AND THROAT.

ABSTRACTS AND SELECTIONS BY C. H. KNIGHT, M.D.

Foreign Bodies in the Nasal Passages.—Dr. H. Stevens recalls attention and gives his approval to the Sajous method of handling these cases. A slender, flexible wire, with its end recurved, is passed into the pharynx, along the floor of the nose. Its end is drawn out through the mouth by means of forceps, and a tampon of cotton or linen is attached. It is then dragged back through the nasal passage, bringing with it the foreign body.—*The Chicago Med. Times*, June, 1887.

Hypertrophy of the Tongue; Macroglossia.—At the recent meeting of the American Surgical Ass'n, Dr. Thos. J. Dunott reported a case of macroglossia in a girl twelve years of age. The organ protruded between the lips for three inches. It was kept enclosed in a muslin bag. Its surface was covered with patches of exfoliated mucous membrane, from beneath which con-

stantly dribbled a sero-purulent secretion. The tongue measured $9\frac{3}{4}$ inches in circumference, and $4\frac{3}{4}$ inches in width, and was almost cartilaginous in consistence. Liquids only could be taken. The protrusion of the tongue had existed only two months, and no cause could be ascertained. The patient being under chloroform, a needle armed with a ligature was passed around the ranine arteries, and the redundant tissue was removed with scissors and scalpel. Microscopic examination showed that the hypertrophy was made up largely of dilated lymph vessels, with increase of connective tissue, and some starited muscular fibres. *Med. News*, June 25, 1887.

Mr. Eustace Callender reports a case of macroglossia occurring in an infant of two months. The tongue was constantly protruded from the mouth, but did not interfere with suckling nor seem to affect the general health. Distinct increase had been noticed since birth.

Dr. Maguire stated that some years ago he had published in the *Journal of Anatomy* an account of the examination he had made in a case of this disorder. He had found that the enlargement of the tongue was due to dilatation of the lymphatics, and these could be seen in all stages of development, until, in the final stage, a cystic lymphangioma was produced. Another case, which he had since examined, presented a similar appearance, and in both cases the tongue affection was complicated by the presence of hygroma at each angle of the jaw. He knew of one case which recovered after the use of Paquelin's cautery.

Mr. Herbert Allingham, while admitting the possibility of nævoid and lymphatic disease as a cause of the macroglossia, had seen cases where a simple muscular hypertrophy existed, and in which cure had resulted from excision of a wedge-shaped piece of the tongue.—*Brit. Med. Jour.*, June 4, 1887.

Contribution to the Study of Hypertrophied Tonsils.—In *Union Médicale*, May 26, 1887, Dr. Albert Ruaault, after minutely describing the two varieties of enlarged tonsils (the hard, or fibrous, and the soft, or adenoid), and the train of symptoms by which each is characterized, concludes that ignipunctine tends to assume an important position in the treatment. Especially in the soft form is it useful. The ease with which it may be used in the form

of a galvano-cautery, renders its universal adoption probable. At the same time the treatment of the co-existing adenoid vegetations in the vault of the pharynx should not be neglected.

The Galvano-Cautery in the Treatment of Hypertrophied Tonsils.—At the last meeting of the American Laryngological Association, Dr. C. H. Knight read a paper on this subject.

He first referred to the objections to the cutting operation. The principal of these is the danger of hemorrhage. At times the tonsil is so deeply situated that it is not possible to get the tonsillotome over it. In other cases the patients positively object to the cutting operation. There are two methods of using the galvano-cautery: one is by puncture, and the other by the snare. The former is much the slower. Not more than three punctures should be made at each sitting. The number of sittings required varies from five to ten. The latter method with the snare is much the quicker. The current should be used intermittently, and traction should only be made during the passage of the current. He did not recommend this as a universal operation. In the majority of cases the cutting operation is easier and better. It should be used where there is danger of hemorrhage, and he was almost disposed to say that the galvano-cautery should be used in all cases in adults.—*Med. News*, June 18, 1887.

Cohen (J. S.) on the Treatment of Laryngitis in Professionals who are Unable to Rest.—He did not know that he was any better able to treat these cases without rest than are others. Sometimes a professional will consult him with hoarseness the result of acute laryngitis, and want to use his voice in a few hours. The best method to accomplish this that he had found has been the administration of a sharp emetic, and then let the patient rest until the time of the performance, sucking pieces of ice and keeping a cold compress to the neck. In chronic laryngitis he had found nothing of the same service as the use of a weak solution of sulphate of zinc, two grains to the ounce, used in a spray apparatus. In the intervals of the play the patient may inhale a little compound tincture of benzoin, if he finds that he is hoarse. Another remedy of considerable service is the use of a respiratory with turpentine, terebene, or eucalyptol, or something of that kind. He sometimes

directs the patient to sprinkle a little turpentine on the floor of the bedroom. He was, however, not aware of any special method which is adapted to this class of individuals.—*Med. News*, June 18, 1887.

Langmaid (S. W.) on the Constitutional Causes of Throat Affections.—He suggested that the most interesting lesson to be drawn from the observation of the lesions in the throat trouble, is that there is some underlying cause which may be external or intrinsic. Our attention has been directed too much to the local condition, and to atmospheric influences. Why atmospheric conditions are active at one time and not at another, is a matter worthy of consideration. One of the most intractable diseases which we have to treat is, chronic recurring coryza. Sometimes destruction of the mucous membrane of the nose is sufficient; but, as a rule, the treatment must take in all the circumstances of the life of the sufferer. A sense of a lump in the throat, so often complained of, is often an indication of an overloaded colon, and more good is done by a dose of castor oil than by local treatment.

The so-called clergyman's sore throat, or follicular laryngitis, has its origin not in the necessary use of the throat, but in the sedentary life which, with errors in diet and other conditions plays an important part. Throat trouble is sometimes a rheumatic or gouty manifestation, and treatment has to be directed to this condition. Local treatment in many throat troubles is of the nature of repair; constitutional and hygienic treatment must be in the direction of a renewal of the normal processes. Swelling and congestion of the mucous membrane, hypertrophy of the tonsil, elongation of the uvula, etc., must be regarded as symptoms, and the symptoms will not be banished unless the underlying constitutional abnormality is removed.—*Med. News*, June 25, 1887.

Glasgow (W. C.) on Measures for the Relief of Congestive Headaches.—The variety of headaches considered in the paper was that from over-distention of the blood-vessels; the so-called brow or catarrhal headache occurring frequently at the menstrual period and called uterine headache, etc. The cavernous bodies are in a state of tension, and the measure for the relief of the pain which he had practised with most satisfactory results during the last four years was local abstraction of

blood, by pricking these bodies with a lance-headed probe. The quantity of blood drawn rarely exceeded one ounce, and in some cases a single drachm gave the desired relief. The bleeding might be repeated.—*Med. Record*, June 11, 1887.

Delavan (D. B.) on the Treatment of Atrophic Rhinitis by Applications of the Galvanic Current.—Some years ago Dr. E. L. Shurley, of Detroit, recommended the use of the galvanic current in the treatment of dry catarrh of the pharynx, and related cases in which benefit had followed its use. He also advocated the same treatment in atrophic rhinitis. There is no disease which is more discouraging to the physician and patient than this of atrophic rhinitis. The author had tried this method of treatment in certain cases. The positive pole of a constant current battery was applied to the nape of the neck, while the negative pole was applied directly to the mucous membrane by an electrode consisting of a copper wire around which absorbent cotton is wrapped. The strength of current employed varied from 4 to 7 milliamperes. In more recent cases of the affection the effect is marked, but even in the older cases the method is not without benefit. The author has found this measure useful in these cases, and reported illustrations. The objection to the method is the amount of time which it requires.—

Four. Am. Med. Ass'n, June 11, 1887.

Atrophic Rhinitis.—Dr. Noquet, of Lille, in some considerations on this theme (*Revue mens. de lareto*, Mai, 1887), claims to cure the disease in many instances, even to regeneration of the atrophied tissues. He uses Weber's douche twice a day, with a tablespoonful of potassium chlorate to the litre of tepid water, followed by pulverization of a solution composed of chloral hydrate, 1 part; boric acid, 12; glycerine, 20; distilled cherry-laurel water, 40; and distilled water, 400 parts. In the middle of the day an additional pulverization is practised with water aromatized with antiseptic vinegar, in the proportion of about one to fifty. After eight days carbolic acid replaces the potassium chloride, in the proportion of about two grammes to the litre. In addition, pencillings are made by the attendant with a solution of zinc chloride (20:100?), rendered limpid by the addition of a small quantity of chlorohydric acid.

The author believes that atrophy is

always consecutive to chronic inflammation, and is inclined to accept Loewenberg's theory, that it is due to a special diplococcus.—*Am. Four. Med. Sci.*, July 1887; also, *Four. Laryngol. and Rhinol.*, June, 1887.

A Consideration of the Results in 327 Cases of Tracheotomy, Etc.

In the *Am. Four. Med. Sci.*, July 1887, Drs. R. W. Lovett and J. C. Munro present an interesting paper with the above title. Ninety-five cases (29.05 per cent.) recovered. All the operations were for croup, so called. An analysis of the cases shows that children are particularly liable to extension of disease to the bronchi. In such cases, death is apt to be slow and painful, a fact to be remembered in recommending operation. The proportion of recoveries varies greatly at different seasons of the year, the percentage of mortality being greatest in the winter months. And it is also noted that the rate of mortality after tracheotomy is in direct proportion with the fatality of diphtheria in general. The authors do not discuss at length the question of identity of croup and diphtheria, but they claim that their statistics give weight to the assertion that they are one and the same disease. The performance of tracheotomy while the dyspnoea is yet moderate, is advocated. Cervical glandula swelling was present in all but 24 cases. Its increase after operation is looked upon as unfavorable. Albumen was found in the urine of five-sixths of the 75 cases in which it was looked for. The character of the discharge from the trachea tube is important. When the discharge was loose and free recoveries were frequent; its suppression was considered a bad omen. The temperature has no more significance than is usual in acute febrile diseases, but a marked rise on the third to the fifth day after operation generally ushered in a fatal result. The presence of membrane in the pharynx at the time of operation gives ground for an unfavorable prognosis. The treatment consisted mainly of stimulation and milk *ad libitum*. Mercurial treatment ($\frac{1}{10}$ of a grain of corrosive sublimate or calomel— $\frac{1}{4}$ of a grain every two hours,) does not seem to have been especially successful.

Treatment of Croup by Calomel in Large Doses.—In the *Gaceta Méd. Catalana*, No. xi., Ano. 80, Rodon Figueras advocates the administration of calomel in doses of 50 centigrammes every hour, from

the first appearance of laryngeal symptoms, before the development of dyspnoea. During convalescence the use of iron is demanded, in order to correct the condition of anæmia, resulting from the mercurial.—*Four. of Laryngol. and Rhinol.*, June, 1887.

DISEASES OF THE EYE.

Bradford (H. W.) Case of Transplantation of the Rabbit's Eye, with Subsequent Enucleation.—In the April number of this publication, 1886, was given a free translation of two French papers by Terrier on the subject of transplanting the rabbit's eye. One of the cases mentioned was by the author now quoted. The case was a middle-aged healthy sailor. The author was the first to suture the stump of the optic nerve to the nerve of the transplanted eye. The only other step of marked difference to the operation as performed by others was the employment of egg albumen to cover the surface of the implanted bulb and for filling the socket. The result of the operation was nearer success than any other recorded. When seen in October, 1885, six weeks after operation, the transplanted globe moved freely and correctly with the fellow. The cornea was still clear in three quarters its extent; the fundus could be seen indistinctly through the widely dilated and immovable pupil. The sailor returned for inspection again in January, 1886. The cornea was then sclerosed and wrinkled, and the whole globe undergoing atrophy. No trouble experienced from its presence. In the following September the atrophied globe was enucleated, no history of any active or passive inflammation being obtainable in the interim.—*Arch. Ophthalm.*, N.Y., June, 1887. A.T.M.

Hogg (J.) Turpentine in Specific Iritis.—This seems to be an old remedy in Dublin, but in the severe case related by the author, where the patient refused, from systemic irritation, the use of mydriatics, especially belladonna, proved itself of great value. The turpentine was taken internally in half-drachm doses, suspended in acacia emulsion after meals, three times a day. For ten months the case had steadily grown worse, retaining only quantitative perception of light. At the end of four months of steady use of the turpentine, without even the adjuvant of mercury, which, in the earlier stages, had done much to re-

lieve, the sight had improved to nearly normal.—*Med. Press and Circular*, Dublin, April 27, 1887. A.T.M.

Pardee (G. C.) Case of Sympathetic Trouble in an Eye Twenty-Two Years After an Injury to its Fellow.

—A steamship engineer, fifty-eight years old, in robust health, came for advice. Twenty-two years ago, while cutting a key-slot in a shaft, a piece of iron flew into his left eye. He was operated upon immediately by my father, who succeeded in extracting from the vitreous, after evacuating the lens, a piece of iron the size of a grain of wheat. The eye was very painful for a few days after the extraction of the iron, but soon recovered. The eye gradually atrophied. Several years afterwards the stump became very painful to the touch, though not otherwise. He did not seek advice, though warned to do so. This sensitiveness persisted unchanged up to the time I saw him. About six months ago the vision of the right eye became periodically affected. A month ago the "cloudiness" became permanent. On examination I found the atrophy of the left eye considerable, and deeply grooved by the four recti muscles. The cornea was almost entirely gone, the remnant of it showing a vertical scar in its upper part extending about two millimetres into the sclera. Palpation extremely painful, and showed a stony hardness; vision zero. The right eye was of normal tension without tenderness on pressure, and presenting nothing abnormal, except a slight cloudiness of the lens. The pupil was small and slightly responsive to light; vision about three fourths. The pupillary edge of the iris was fastened to the capsule of the lens. The patient denied ever having any pain or redness in the right eye. He accepted the advice for immediate enucleation. And the left globe was removed under the influence of cocaine. The globe was found flattened to about one fourth its natural size, and stony hard. On removing the remains of the cornea, it was found that the entire inner surface of the sclera was lined with a bony and membranous capsule. Behind the inner and upper part of the cornea this capsule was a tense membrane. And here bony spiculæ could be felt in its substance. On cutting into this capsule it was found to be hollow, containing a few drops of a clear fluid, the remains of the vitreous. From the optic papilla to the

edges of the remnant of the cornea stretched a thin white cord, the remains of the detached and atrophied retina. Since the operation the right eye has been steadily gaining acuteness of vision. This case is peculiar for two reasons. First, the length of time between injury of one eye and appearance of sympathetic trouble in the fellow eye. And besides, the extent of the intraocular calcification.—*Pacific Med. and Surg. Four.*, May, 1887. A. T. M.

Hotz (F. C.). Case of Partial Trichiasis Relieved by Stellwag's Method of Reversing and Replanting the Ciliary Border.—The patient had previously been operated upon by Dr. Montgomery, who used his own method of transverse ligation. The result had been eversion of the lateral portions of the lid operated upon, but no effect gained on the middle portion. Two parallel incisions were made after the most careful antiseptic precautions; the flap with the lashes was laid in cloths damp with warm bichloride solution, and the wounded surfaces inspected so as to remove all bulbs not included in the flap. The oozing took long to stop; when it had, the flap already mentioned was replaced in a reverse position. More antiseptis was practised, and then the two eyes were occluded by bandage for three days. Complete union of flap was found; the bandage was re-applied for two days more. The lashes at first were 4 mm. from the ciliary border, but contraction brought them well into line. The principal criticism made coincides with that of the author of the operation, that the lashes fell out, leaving only two out of twelve. If the operation had taken in the whole lid, no doubt the disfigurement from this cause would leave little to prefer to the operation known as scalping, where all are removed.—*Am. Four. Ophthal.*, May, 1887. A. T. M.

Mule (P. H.). Entire Freedom from Pain and Undue Reaction after Evisceration and Introduction of the Glass Vitreous.—The cause for the pain is the pressure produced by a rapid pouring out of serum into the subscleral space, with subsequent infiltration and tension of the orbit. Severe pain has always followed evisceration, and the introduction of the glass sphere has in nowise increased or diminished this. Dr. Lang has removed the whole sclera in hopes of preventing the pain, without success. In two cases I had

just completed the following method was employed with great success. After taking all the steps usually comprising the operation, the external canthus is cut, burrowing freely back into the orbit with a pair of sharp scissors, taking special care to open the subscleral space; introduce an antisepticised horse-hair drain, the cut ends just passing through the cut canthus; apply a dry, thin, absorbent pad, and an ice-bag over all.—*Brit. Med. Four.*, June 4, 1887. A. T. M.

MEDICINE.

Leloir (H.) on Cutaneous Affections of Nervous Origin. Dermatoses Produced by Moral Shock.—Among the diseases which may be so caused the author mentions cutaneous anæmias, hyperæmias and hemorrhages; erythema, urticaria, purpura; superficial and catarrhal inflammations of the skin; psoriasis; therpiz; pemphigus and vitiligo.

Most are characterized by a rapid onset following a moral shock or nervous commotion. When they do not immediately follow their nervous cause there are often seen various phenomena of cutaneous neuroses, pruritus, neuralgia, etc., which precede, perhaps, by some days the dermatosis. The elementary lesions appear rapidly, almost at a single stroke, instead of in successive outbreaks. These dermatoses are all superficial and are almost all accompanied by excessive itching; last only a short time, and more often attack women.

Two factors conspire to their production, an impressionable subject and a predisposition to skin diseases.

Preventive treatment should consist in the avoidance of fatigue and excesses, good hygiene, exercise in the open air, nourishing food, regular hours, and avoidance of tea and coffee.

Certain nervous sedatives are useful as arsenic, the bromides, and the shower bath. In the treatment of the dermatoses, nervous sedatives should not be forgotten.—*Am. de Dermat. et de Syph.*, June 25, 1887.

Westbrook (B. F.) on the Local Treatment of Diseases of the Respiratory Organs.—The methods of treatment which have been employed were the direct introduction of coarse sprays, the use of the Evans inhaler, and the use

of the pneumatic cabinet. In cases of chronic bronchitis, where the cough was severe, a spray of solution of carbolic acid, fluid extract of hyoscyamus, or other sedative remedies were employed. Where there is copious secretion, astringents are called for, and of these, tannic acid, iron, salts, and fluid extract of pinus canadensis had been employed. The pneumatic cabinet had been used with marked success in the treatment of chronic bronchitis. The patient is confined in the cabinet under a diminished pressure, the sitting lasting from ten to fifteen minutes. This may be combined with the inhalation of the spray. If there is much emphysema the cabinet is not indicated. In using the cabinet in the treatment of chronic interstitial pneumonia and bronchiectasis, there is danger, if the pressure is great, of producing emphysema of those portions of the lung still accessible to the air. The pressure should not exceed one-half-an-inch of mercury.

In the treatment of phthisis, the best results are obtained in the early stages of the disease, or where the disease, although further advanced, is limited to a smaller portion of the lung. The use of sprays is beneficial in only so far as we desire to treat the co-existent bronchitis, or cavities connected with bronchi of the second or third order. In incipient phthisis, with very little bronchial catarrh, local treatment is probably of little service. These cases are best treated with compressed air. In a large proportion of the cases, we may hope to render the disease latent. The expansion of the lung favors the expectoration of the contents of the smaller tubes, and modifies the intrathoracic circulation. The sittings should be frequent—every day, or every second day. Ten minutes is usually sufficiently long for the patient to remain in the cabinet. The pressure should gradually be increased up to one-half to three-quarters of an inch. If used cautiously, this is the best method for the local treatment of incipient phthisis. With the Evans inhaler, his results had also been satisfactory.

In the treatment of advanced cases of phthisis, the first effort must be to cure or diminish the bronchitis. The pneumatic treatment then comes into play. This gives better expansion, improves the circulation, and alters the action of the trophic nerves. In all cases, internal medication has been combined with the local treatment. The more acute the disease, the higher the fever;

and the more sudden the onset, the less can we expect to accomplish by treatment. In no case diagnosed as acute phthisis did treatment have the slightest effect.—*Bost. Med. and Surg. Jour.*, June 23, 1887.

McGaskey (G. W.) on a New Method of Intra-Pulmonary Medication.—The author is not in favor of powders, gases, or sprays, for introducing such medicinal agents, but relies on saturated vapors at a temperature of 158° Fahr., or in exceptional cases a somewhat lower temperature.

He uses a special apparatus, which comprises a double-walled chamber, with a capacity of one cubic foot, the hot air of which can be saturated with the vapor of any soluble agent. Respiration is carried on continuously by a combination of valves, the patient inspiring from the chamber and expiring into the air of the room. He uses a wet and dry bulb thermometer to determine when saturation is complete. Its use with the pneumatic cabinet the author believes to be of great advantage. He has had considerable experience in the treatment of bronchitis and phthisis, and apparently has had more gratifying results than are usually obtained with the pneumatic cabinet alone.—*Med. and Surg. Reporter*, June 18, 1887.

Fussel (M. H.) on Gastric Pain.—Wm. G., carpenter, aged 41 years. Habits good; always been accustomed to eat much indigestible food. For one and a half years been suffering from severe epigastric pains; worse after eating; relieved by lying on the back; no vomiting; some flatulence; tongue flabby and coated. On examination there was found much tenderness in the epigastrium. He was put on a pill of $\frac{1}{4}$ gr. silver nitrate and $\frac{1}{8}$ gr. pulv. opii. His bowels were regulated by cascara sagrada. Almost immediately his pain began to subside, tenderness became less marked, and at the end of two weeks he considered himself cured. He received no other drugs, except for a short time a mixture of tr. gentian and nitro-muriatic acid. At the present writing he remains well, with still some dyspepsia, but the annoying pain entirely relieved.

Robt. P., merchant, aged 71, married. Good habits. Had always been in the habit of eating cakes and cheese between meals while attending to his store. For a number of years has had much flatulence after eating, but considered himself well

until a year previous to his appearance at Prof. Osler's clinic. Suddenly, in the night, one year before, he was seized with a severe attack of epigastric pain, relieved by morphia. In two or three weeks had a similar attack; neither of these accompanied by vomiting. These attacks were repeated four or five times, when their character suddenly changed. The pain became less marked, but was still present; but now he was attacked by distressing nausea and vertigo. The vertigo was so violent that he would fall. Some of the attacks were accompanied by purging. In the past year he has lost fifty pounds in weight. On examination by Prof. Osler his abdomen was flat; no evident tumor, but an unnatural tenseness. A spot of tenderness was found just below the ensiform cartilage. This case was at first regarded as possible gastric cancer; but subsequent developments showed its true nature to be a gastric catarrh, with gastralic attacks. He was put on a powder of bismuth subnit, 10 gr.; soda bicarb, 5 gr.; morph. sulph., $\frac{1}{2}$ gr. In two weeks he had another attack; but the intervals lengthened, and he is now, a year and a half after the first visit, apparently entirely well.

The treatment of these two cases is that which is followed as a rule in such cases in my room of the dispensary. It is usually successful. The silver and opium are used in the class of cases without marked flatulence, while the above powder is used where flatulency is a marked symptom.—*Med. and Surg. Reporter*, July 9, 1887.

Quaife (F. H.) on a Case of Stomatitis with Jaundice.—Several years ago I saw, within a few weeks, a number of cases of stomatitis in children, which affected several in one family, and appeared to be contagious. The symptoms were those of superficial inflammation of the mucous membrane, viz., deep redness of the whole mouth, extending down into the throat as far as could be seen by ordinary means, with great sensitiveness to touch, or heat or cold, so that swallowing was dreaded. There was a good deal of increased secretion from all the glands of the mouth, and often enlargement of the submaxillary and sublingual glands; and there were numerous thrush-like white points on the insides of the cheeks and the tonsils. I do not recollect any decided swelling of the last-mentioned glands. There was generally a good deal of fever present, and these

symptoms all lasted about a week, and in all the children ended in recovery. During this time I was called to see an old lady, of thin and spare habit, for sore throat, and on examination found a precisely similar state to that described above: there was a good deal of fever, and in this case diarrhoea and great thirst. The soreness of the mouth and pain on swallowing, with the feverishness, alarmed the patient, and her husband and I cheered her up with good hopes that nothing serious would ensue, but, unfortunately, I was too sanguine. The diarrhoea, which had been in existence for some days before I saw the patient, proved intractable, and while the mouth and throat improved, soon jaundice appeared, and in a few days the old lady sank and died. I prevailed on the husband to let me examine the alimentary tract, and I found that the inflammation extended from the mouth down into the ileum, and was very marked in the duodenum, and on opening the liver and tracing up the ducts from their outlet, the lining membrane of these was found to be swollen and highly congested as far as far as could be observed. The thrushy appearances in the mouth were well marked, but I do not recollect any such appearance in the bowel, or in the duct of the liver. A few cases of a similar affection to the above have occurred recently (last year) in children, but not to near so great an extent as at the time referred to. I think there can be no doubt that in the fatal case the mischief began as the same mouth affection as in the children, and that, owing to age and want of the resisting power of youth, it spread rapidly along the alimentary canal. In none of these cases was there any affection of the chest, nor were there laryngeal signs, either spasmodic or inflammatory.—*Australasian Med. Gaz.*, June, 1887.

Wade (C. H.) on the Treatment of Epistaxis.—I was hastily summoned to attend a laborer, æt. forty, who, according to the messenger, was "bleeding to death." I found him seated on a chair before a large fire, in the kitchen of his cottage, holding a duster, already saturated with blood, to his nose, and surrounded by sympathizing relatives and friends; while hard by were evidences, in the shape of blood-stained rags, and a bowl of reddened water, to the effect that the hemorrhage had been continuing for a considerable

time. On inquiry I learned that it had lasted from about one o'clock in the day, and the sufferer himself volunteered the information that his condition might have been influenced by the fact that, in deference to the season, he had taken "his beer" in more liberal quantities than usual. On removing the cloth with which he sought to stay the flow, the blood dripped freely, and the same rate was said to have been maintained for several hours. The man's appearance quite justified the truth of this assertion, and I determined at once to fall back on hot pediluvium, having from prior experience, complete faith in its efficacy. Fortunately a pan of water was on the fire at the time, almost boiling, and half-filling a couple of buckets with it, and adding enough cold water to render the bath tolerable, I placed a foot and leg of the patient in each. I must admit that my proceedings up to this point did not perceptibly impress my audience with a sense of my dignity as a surgeon, but almost immediately thereafter the drop, drop, from the nose of the patient was arrested, and within eight minutes it had entirely ceased. It need hardly be said that he had previously, at my request, been lifted in his chair, from out of the direct heat of the fire to a cooler situation, and as he showed a tendency to faintness he was also for a time supported by bystanders.—*Med. Press*, June 1, 1887.

Ingals (E. F.) on Epistaxis.—The author concludes that :

1st. In ordinary cases, epistaxis ceases spontaneously ; therefore, it makes no difference what innocuous treatment is employed.

2d. Epistaxis in children and young adults is generally an effort of nature to relieve plethora, and therefore should not receive active treatment.

3d. Persistent or frequently recurring bleeding from the nose may sometimes be relieved by constitutional remedies, but it usually demands topical treatment.

4th. When bleeding is profuse, it may often be checked by insufflations of cocaine, or the vegetable astringents, which may, if necessary, be supplemented by plugging the nostrils.

5th. When it cannot be checked in this way, the nasal cavity should be treated with iodoform, and then thoroughly plugged from the front with a strip of gauze saturated with tannic acid. This

method will nearly always be successful, and, therefore, tamponing of the posterior nares, which is sometimes dangerous, should be employed only as a *dernier ressort*.

6th. In nearly all cases the source of hemorrhage may be detected by careful rhinoscopy.

7th. In these same cases the affection may generally be cured by the judicious use of solid nitrate of silver, or, better yet, by the galvano-cautery.—*Med. News*, July 23, 1887.

Heebner (T. F.) on the Pulse and Nervous System.—At the close of his paper, which is mainly suggestive, the author asks some very pertinent questions. He says : "Are we in our daily routine of practice using the best therapeutics in our treatment of diseases in which we find abnormal pulses ? Should we not use nerve stimulants in some and nerve sedatives in others to control the circulation ? Should not the condition of the vaso-motor and sympathetic systems be more carefully sought for ? Should we not in the touching of the pulse be more careful before assuming too much importance from its rate, quality, and quantity ? Should not nerve stimulants be more serviceable in the "toning up" of the circulation in many cases than heart tonics ? Should not the sphygmograph be brought into more general use, if not in ordinary cases then in those of great import ? Can we truly gain a correct idea of the circulation without a thorough examination of the heart, venous, arterial, and nervous systems collectively ?"—*Med. Register*, June 11, 1887.

Broadbent on the Pulse.—Dr. Broadbent discusses, first, abnormalities of rhythm, such, for instance, as persistent frequency, paroxysmal palpitations, the infrequent pulse, the intermittent and the irregular pulse ; next, the fluctuations of tension ; and, lastly, the special effects upon the nervous system which these tension-alterations entail. Now all these matters are to be met with every day, even by those of limited experience, and no doubt what the lecturer has to say will have been scanned eagerly for guidance. What, for instance, can be more distressing than the several forms of persistent frequency of the pulse, both with and without valvular disease, and how little remedies seem capable to control it ? Take, again, the case in which the heart shies and bolts at

the rate of two to three hundred per minute. These conditions are by no means uncommon in one form or another. Who is there that can say for each and all of these varied palpitations this remedy will suffice for the one, that for another? Not one. The conditions which originate the wayward activity are apparently too complex to justify any dogmatic therapeutical generalization.

Then there is the bigeminal pulse and its varieties: the pulse which misses a beat, which beats in pairs and then pauses, or gives a faint shuffle for a beat or makes a first sound and even a second without transmitting a corresponding pulse at the wrist. Dr. Broadbent seems to adopt as the explanation for the pulseless beat, that the two sides beat asynchronously. Because of the existence of a pulmonary second sound and the absence of an aortic one; with the feeble beat the presence of a double impulse, one to left and one to right; and the occurrence sometimes of a mitral systolic murmur with the one beat, and a tricuspid systolic with the other. But these are all criteria concerning which it is somewhat difficult to be quite certain, and there is much also to be said for that other view which allows a greater latitude to irregular and abortive muscular action on the part of the left ventricle.

We may next turn to intermittent and irregular pulses. Common as they are to meet with, we should gladly know of a surety much more about them. How do the irregular pulses which forbode ill to the patient differ from those which allow of a protracted life and average of health? "I cannot," says the lecturer, "fix any prognostic value to irregularity of the pulse as such." And that is about all that can be said, little as it is, to our comfort. Irregularity, as such, tells us little, since it is well known to be compatible with many years of life. It is the condition under which we surmise that it has come into operation, that constitutes the important factor in leading to a right construction of the prognostic value of this symptom; and it is not unimportant that this should be clearly stated.

With regard to tension, an interesting subject is opened in treating of the effect of anæmia. It is, as Dr. Broadbent says, not easy to understand how anæmia can give rise to high tension in the pulse; yet the difficulty is, perhaps, one of our own

making, for there is no reason why the passage through the tissues of poor blood should not be resisted as actively as any other kind of qualitative change, and there are evidences which could be adduced, both pulmonary and systemic, to show that this is at any rate sometimes the case. It may, however, be doubted whether it is so as often as would seem from the insistence thereupon which has characterized the teaching of the last few years. It is not improbable that some of the difficulty experienced in the reception of this particular teaching is the outcome of the experience that anæmia and a soft pulse are the associated conditions with which most of us are familiar.

The remarks upon the treatment of increased tension are full of meaning—none, perhaps, more so than that, although encompassed by many risks, abnormal tension is not necessarily to be attacked whenever it exists; also that the prognosis in renal disease is unfavorable in the absence of what is the gauge of the ability of the heart to accomplish the extraordinary call. Dr. Hare, we believe, claimed for bleeding and blue-pill that they were, with others, good remedies out of fashion, and Dr. Broadbent fully endorses this.—*Brit. Med. Jour.*, April 16, 1887.

Poncet on Recovery from an Epithelial Cancer.—A man presented himself in 1885 with an epithelial tumor of the floor of the mouth which had destroyed the frenum and become adherent to the jaw. This tumor had existed eight months, and had been twice removed. Poncet ligated both carotids and resected a large portion of the lower jaw, which appeared healthy. A prothetic apparatus was made to remedy the deformity.—*Lyon Méd.*, June 19, 1887.

Henry (W.) on Rheumatism.—The author narrates his treatment in two cases of inflammatory rheumatism.

In one case he rolled every joint in cotton wadding. He then prescribed veratrum viride to control the pulse; gave opiates in the form of Dover's powder, as much as fifteen grains at a dose. He also, during this time, gave alkalies in the form of bicarbonate potassa, ten grains, every three hours.

Under this treatment the pain and swelling began to subside, but he still kept on the cotton, which kept up a mild perspiration.

The second case was a young man, aged nineteen. He was troubled with rheumatism of the joints and also of the heart. Upon auscultation he found great irregularity of the heart, but as yet the valves did not appear to be affected. He therefore placed a whole bat of cotton wadding over the region of the heart and gave digitalis, tr. of drops five, every three hours, and Dover powder in large doses. He also gave bicarbonate potassa, and in less than four days most of the symptoms had ceased, and in less than one month he was well, except being weak from exhaustion of the heart.—*Med. Register*, June 18, 1887.

Williams (C.) on a Case of Progressive Muscular Atrophy; Demonstrating the Nervous Origin and Nature of this Disease, and its Amenability to Nervine Tonics.—Recognizing the fact that the disease clearly shows absence of tone in the nervous system, it was not difficult to see that nervine tonics and not nervine sedatives were what were required. The internal consisted in administering a mixture of iron and strychnine, and the external in the local application to the affected muscles of the magneto-electric current. The medicine was taken uninterruptedly for as long as two years, while the local treatment was discontinued after about twelve months. As to the part each played in the resulting improvement my own opinion is very decided, and that is, that while both combined helped to give the first check to the disease, the medicine alone has held it back since. Asked what ingredient in this mixture I attribute most virtue to, I should unhesitatingly answer that it was the strychnine. Whilst in the beginning he persevered with it regularly, and under it slowly but surely made progress; afterwards, when better, he always used to come whenever there seemed to be a slight relapse, and a bottle or two of the mixture almost invariably pulled him together again.—*Bristol Med.-Chir. Jour.*, June, 1887.

Reynier on the Patellar Reflex in Diabetics.—The author had performed surgical operations upon seven diabetics. In five of these the patellar reflex was absent: in two it was present. The two latter alone recovered from the operation. The author, for this reason, thinks the absence of this sign should lead to a grave prognosis in such cases. Berger reports

confirmatory cases; a diabetic with an enormous gangrenous phlegmon of the ischiorectal fossa, having no patellar reflex dying while another with diabetic gangrene but preserved patellar reflex recovering.—*La France Méd.*, July 9, 1887.

Baker (L. W.) on Mental Disturbances Following the Cessation or Diminution of Epileptic Attacks under Treatment.—Anti-convulsive treatment should not be too readily abandoned when mental disturbances follow the cessation of convulsive seizures. In these cases the brain has become accustomed to excessive discharges of nerve force, which occasion muscular convulsions; when this tendency is controlled by treatment the equilibrium of the nervous centres is for a time destroyed, the discharge then becomes mental, rather than motor, and there ensues a convulsion of ideas instead of a convulsion of muscles. If the anti-epileptic treatment is combined with cod-liver oil, phosphorus, and other nerve tonics, the brain may gradually return to the condition in which it was before the attacks were controlled.

Of course in these cases it is important to distinguish between this condition and that which is occasionally produced by large doses of bromide of potassium, but in the majority of instances, it will be found that the mental disturbance is due to the cessation of convulsive attacks rather than to the effects of the drug.—*Bost. Med. and Surg. Jour.*, April 28, 1887.

Jacoby (G. W.) on Thomsen's Disease.—At the commencement the author quotes Erb's definition of the affection.

"I understand by the typical form of Thomsen's disease those forms of disease which generally, under the influence of an hereditary or family noxiousness, already in very early youth show that disorder of movements which later becomes more pronounced. The occurrence after a period of rest, and during movements, of tension and stiffness of the muscles up to complete inhibition of movement, gradual dissolution of this tension by means of continued movement, until entire relief occurs. Prolongation of the tonic contractions, produced by energetic action of the will, and inability to voluntarily relax the muscles quickly. In connection with this a remarkably strong, hypertrophic development of the voluntary muscles, in direct contrast to their relatively small power."

The author concludes that : Clinically, Thomsen's disease appears to be an affection of the muscles alone, and microscopically this probability is only confirmed. There can be no doubt that this disease is a congenital malformation of the muscular fibres, as it is proven by the augmented size of each individual fibre, and by the increase in the number of their nuclei and of the perimysium.

In Thomsen's disease, the motor nerves and motor end-plates do not show any deviations from the normal. The nerve-impulse, therefore, is transmitted into the muscle-fibre in the same manner as in the normal condition.

The result of this reception of impulse will be a contraction which, especially after a certain rest, will be a hypercontraction, or rather tetanus. This tetanus leads to an agglomeration of a certain number of sarcous elements, with a break in the continuity of the contracted clusters, as can be plainly seen under the microscope. In consequence of this tetanus, the nerve-influence is inhibited for so long as the tetanus lasts. After the lapse of a few seconds, the tetanic contraction will subside, the continuity between the hitherto separated groups of sarcous elements will become re-established, and the propagation of nerve-influence again rendered possible.—*Four. of Nerv. and Ment. Dis.*, March, 1887.

Coe (H. C.) on the Clinical Versus the Microscopical Evidences of Malignant Disease.—There is no real antagonism between the results obtained, unless truth is antagonistic to itself. It is the observers and not the observations that are in opposition. Eliminate the personal equation, and the extremes tend to meet. The practitioner ought to feel that his work is supplemented by that of the pathologist, while the latter would do well not to be above using all the clinical data that he can obtain with regard to the patient from whom a given specimen was removed. Instead of submitting questions to a microscopist as if the object was to catch him in an error, the profession ought to furnish him with all the information possible, so that he may take up the clew where it was dropped, as it were. So important is it to exhaust every means of arriving at a correct diagnosis in cases of suspected malignant disease, and so weighty is the question of prognosis, that we cannot

afford to neglect a single aid. Continued observation of the patient, repeated physical examinations, and a frequent resort to the microscope, can alone clear up obscure points. If this course is adopted, the apparent discrepancy to which reference was made will generally be reconciled. But if "snap-diagnoses" are indulged in, either at the bedside or in the laboratory, gross errors can hardly be avoided.

We ought not to be satisfied with a single line of investigation if it tends to dwarf our views. If it is foolish for the severely practical man to esteem lightly the revelations of the microscope, it is equally reprehensible for the special worker with that instrument to study disease through its lenses alone.—*N. Y. Med. Jour.*, June 18, 1887.

SURGERY.

Hannequin on Subluxation of the Axis with Fracture.—A young man fell from his horse striking so as to flex his head strongly forward and to the right. He experienced some pain in the neck. He simply kept his room. A month later he entered the hospital with the mumps. These disappeared, but still he complained a little of his neck. On examination there was found, below the occipital protuberance, a sensitive depression. Lateral movements of the head were absent. In trying to elicit them crepitus was produced. From the pharynx a conoidal tumor projected which resembled the anterior tubercle of the axis. It was tender, and pointed slightly to the left.—*Lyon Mtd.*, June 26, 1887.

Gerster (A. G.) on Exsection of the Knee-Joint for Tuberculosis.—White swelling of the knee-joint in adults of the laboring class can, for various external reasons, rarely be treated by orthopædic measures. In children a rational mechanical and general treatment will often reward the patience and skill of the physician by excellent results. Exsection of the infantile knee-joint is to be avoided as long as possible on account of the great shortening that is caused by the removal of the epiphyses adjoining the knee, on which depends the growth of the thigh and tibia. In adults, exsection is the shortest and safest way of eliminating the tedious and morbid process, and substituting firm an-

kylosis for a useless joint. Arthrectomy, or exsection of the capsular ligament alone, as suggested by Volkmann, has not been attended with good success in the experience of the author. Two cases—one in an adult, the other in a child—resulted in relapse of the tubercular affection, although great care was taken in removing the entire capsule. A third case was permanently cured.

Total exsection of the knee-joint is usually done by the author in the following manner: After careful scrubbing and disinfection of the region of the knee, the foot and leg and the thigh of the diseased limb are wrapped in clean towels wrung out of corrosive-sublimate lotion. The limb is held elevated in the vertical position for five minutes to deplete its vessels, and the constricting elastic band is applied well up near the root of the thigh. The knee is flexed, and an incision, commencing at the middle of one condyle of the femur and extending in a semi-circular line *above the patella* to the middle of the other condyle, is carried into the joint.

The transverse incision above the patella, proposed by Eugene Hahn, of Berlin, has many advantages over the incision made below the knee-pan. The chief one is the free access it affords to the bursa of the quadriceps, which must be carefully exsected along with the capsule.

The crucial ligaments are cut close to their attachment to the femur, and the patella, semilunar cartilages, and entire capsule, together with the bursa of the quadriceps, are exsected with mouse-tooth forceps and curved scissors. Care must be taken not to overlook some small bursæ situated behind the head of the tibia, which regularly communicate with the interior of the joint. The condyles of the femur are sawed off, the plane of section corresponding to the transverse diameter of the epiphysis of the femur.

Disregard of this rule will lead to ankylosis in the bow-leg position.

The articular aspect of the tibia is sawed off at a right angle to the long axis of this bone. All visible orifices of vessels are secured by ligature. They can be made visible by compressing the vicinity of the wounds with both hands. If the transverse incision has not been made long enough to permit of an easy arrangement of the drainage-tubes in the angles of the wound, it should be sufficiently lengthened. The

inner ends of the tubes should reach into the popliteal space, just behind the sawn surfaces, and the tubes must not be compressed and occluded by the tension of the soft parts surrounding them. The limb is placed upon a long cushion covered with a clean towel wrung out of corrosive-sublimate lotion, and, while the sawn surfaces are held in exact apposition, two or four long steel nails, previously well disinfected by heating in an alcohol flame, are driven diagonally through femur and tibia, so as to firmly lock the bones in the desired position. The cutaneous incision is united by a sufficient number of catgut stitches. The limb is raised by the foot from the cushion, which is then removed. Strips of disinfected rubber-tissue are slipped under the safety-pins, securing the ends of the trimmed drainage-tubes, and an oblong compress of iodoform gauze is laid over the entire line of union. A suitable number of sublimated gauze compresses are arranged around the knee joint, and two short lateral splints of veneer or thin board are firmly bandaged on to serve as a deep support. Over these comes an ample external dressing of corrosive-sublimate gauze, also firmly held down by a gauze bandage. The towels are removed, and the uncovered parts of the limb are enveloped in a layer of borated cotton to equalize the outline of the extremity. Two long lateral pasteboard splints, held down by a muslin or crinoline bandage, complete the dressing for children or adolescents. The more voluminous limbs of adults are better secured by a solid circular plaster-of-Paris splint. The limb is vertically elevated and the constricting rubber band is removed. Return of circulation is attested by the pink color of the toes. As soon as these turn pale, the extremity can be brought into the horizontal position.

If asepticism has been well maintained, little aseptic fever and no severe pain will follow the operation. The dressings should remain undisturbed for thirty days to afford a good chance for bony union. After thirty days the splints and dressings can be removed, and the nails and drainage-tubes can be withdrawn. The remaining sinuses are to be dressed lightly, the limb is incased in a silicate-of-sodium splint, and the patient is ordered to walk about on crutches, whether osseous union is present or not. Gradually the use of crutches is dispensed with, and the patient generally learns to

walk very well on an elevated sole compensating for the shortening.

In twelve cases of total exsection done by the author for tuberculosis ten were cured with preservation of the limb, one was followed by amputation of the thigh, one case died of tubercular meningitis.—*N. Y. Med. Jour.*, June 11, 1887. G. B. P.

Felkin (R. W.) on a Case of Dislocation of the Ulnar Nerve and Fracture of the Radius.—Miss A. D., aged 21, residing in Edinburgh, fell heavily on her right elbow on January the 12, 1886. She was running at the time, both hands being in a muff, which was suspended round her neck by a cord. The day was very slippery, and she said that her feet went from under her, and that she fell with her whole weight on the elbow. She complained of extreme pain at the elbow, and in the little and ring fingers, which were flexed. On examination, I found that the arm was flexed at an angle of about 90°. The elbow was considerably swollen, and what appeared to be a tight band extended from two inches above the internal condyle of the humerus to a point about $\frac{1}{4}$ of an inch below the band of the elbow. On touching this band, my patient complained of extreme pain, like "pins and needles," which extended down to the little and ring fingers. I diagnosed dislocation of the ulnar nerve, and after some considerable difficulty, managed to restore it to its normal position. I then found an oblique fracture of the radius, rather more than an inch below the head. I endeavored to apply a rectangular splint, but was unable to keep the nerve in position, so that for the first few days I put on a straight anterior splint, and ordered evaporating lotions to be applied to the elbow. On the fifth day all swelling had disappeared, and I was able to put up the limb on a rectangular splint. For the next three weeks my patient complained exceedingly of pains of a neuralgic character, and numbness in the little and ring fingers, which remained strongly flexed. At the end of a month I removed the splint, and commenced passive movement, and all went on well for a fortnight, when my patient slipped, and saving herself from falling with the right hand, the nerve was dislocated again, and I had to reapply the splint for another fortnight. From this time satisfactory progress was made.—*Edinburgh Med. Jour.*, July, 1887.

Hamilton (C.) Cæsarian Section Performed Successfully on a Cow.—

On the 20th day of April I was called some distance in the country to see a patient. On my arrival I was asked by the patient's father to come out to the barn-lot as soon as I had made my prescription. On going out to the lot I found a cow in labor which had been existing for about twenty-four hours. On examination I found that, owing to an injury she had received on the railroad, there was not passage for the calf; its forefeet were presenting, and there was no room for the passage of its head. The gentleman insisted on saving the life of the calf, so I concluded to perform Cæsarian section, though I had never heard of this operation being performed on a cow. So without the use of any anæsthetic I began the operation. I made an incision a little to the right of the median line, commencing just at the edge of the mammary glands, and, cutting up, made an incision six or seven inches long—the cut in the uterus being as small as would possibly admit the escape of the calf. As the membranes had not ruptured, I waited a few minutes for the sack of water to form (which it did very readily), so as to dilate the cut in the womb. I then ruptured the membranes and delivered the calf, and in a few minutes it was up walking around. I used a catgut suture in closing the cut in the uterus and abdominal walls, and in a few minutes after the cuts were closed the cow got up and let the calf suck. There was very little swelling or suppuration. The lochial discharge commenced at once from the vagina and continued its usual time. I instructed them to feed her on meal and bran for fifteen or twenty days. She has been giving sufficient milk for the calf all the time, and at this date is doing well, running on the range with the rest of the cattle. The contraction of the uterus at the cut was just the same as at the mouth of the womb, showing very plainly that the contractility of the uterus is in every way, while the uterus was cut latterly the contraction was uniform, and the pains were as regular as natural labor; the cow, while operating, struggled but little; what little she did seemed to assist in delivery.—*So. Practitioner*, July, 1887.

Freeland (J. T.) on the Treatment of Infantile Hydrocele.—In looking over the records of this institution, I found

that one thousand one hundred and fifty-seven cases of infantile hydrocele have been treated here in the dispensary department. The treatment of this class of cases has varied at different times; but I notice that the change in treatment has been from the severe (*i. e.*, setons, iodine injections, drawing out through an incision and snipping off a bit of tunica vaginalis) to the mild, and the results are now as good as they have ever been.

We first prescribe

Tr. bellad.,

Tr. iodinae, cc. aa ʒj.

M. Sig.—Apply over hydrocele twice daily.

This is generally sufficient to relieve within a week or two, especially so if the infant is but a few weeks old.

If this fails to cause absorption after a fair trial, the fluid is drawn off by a hypodermic needle or a small trocar. It may be necessary to draw the fluid a second time, rarely a third; as the fluid does not show the tendency to reaccumulate in children as in adults. This last point is an important one, and should have much to do in changing the treatment generally employed by physicians.

The treatment given is applicable to all the forms of hydrocele, congenital, acquired, diffuse, and encysted of the cord.—*Med. and Surg. Rep.*, July 2, 1887.

Tiffany (A. McL.) on the Surgical Diseases of the White and Colored Races Compared.—The paper was based on the record of four thousand nine hundred and thirty cases studied during a period of thirty-four months in a general hospital. The percentages of the affections were given in detail. The paper was simply intended as a preliminary communication, and, as a result of a study of the figures obtained, the following suggestions were made:

1. Surgical affections follow different courses in the white and colored races under identical hygienic surroundings.
2. Surgical injuries and operations are better borne by negroes than by whites.
3. Surgical diseases involving the lymphatic system, especially tubercular, are more fatal and more rapidly fatal in negroes than in whites.
4. Congenital deformities are rarer in negroes than in whites.
5. The surgical differences observed in whites and negroes are due to racial peculiarities.—*Med. Times*, June 25, 1887.

Treves on the Treatment of Wounds.—Wounds of the lower extremity heal more imperfectly because they are in a close, not to say fetid, atmosphere under the bedclothes. The limb should be wrapped in cotton wool and exposed to the air. If sheaths of tendons are opened they should be carefully closed. In removal of the toes, the artery of the flap should be preserved intact. The author never used plaster-of-Paris for compound fractures of the lower limb, his plan was to fix the fractures by straps and buckles, to expose the limb freely to the air, and to keep the wound constantly powdered with iodoform until a firm scab is formed. In wounds of joints, the author had found great benefit from irrigation; in a bad case water was kept flowing through the knee-joint for a month. In operation wounds preference was given to dry sponge dusted with iodoform.—*Provincial Med. Jour.*, July 1, 1887.

Abbott (F.) on the Implantation of Teeth—Younger's Method.—The operation is performed in the following manner: A tooth for the place is first selected, the pulp-chamber opened, and the pulp from that and the canal as perfectly removed as practicable, and the canal and drill-hole are filled; it is then placed into an antiseptic solution (bichloride of mercury, 1 to 2,000). A cross is then cut through the gum to the bone, at the point where the socket is to be made to receive the tooth. The corners of the gum thus made are slightly dissected from the bone, and a trephine the size required is then inserted through the opening in the gum, and driven with the dental engine to within about a fourth of an inch of the depth desired; the remainder of the socket, owing to its tapering shape, is finished with different sized and shaped burrs and reamers. When, in the judgment of the operator, the socket is about the size and depth to receive the tooth, he tries it; if the tooth fits as desired the operation is proceeded with; if not, the tooth is removed and the socket enlarged in this manner, cutting and fitting until the tooth stands in the socket in a correct position. The tooth is then removed and again placed into the antiseptic. The socket is now washed out thoroughly with the antiseptic, and the tooth placed in position. In some cases it is necessary to ligate it to adjoining teeth for a time; in others it is

held as firmly as required by the impinging walls of the new socket. The gum over the tooth is then painted with equal parts of the saturated tincture of aconite root and the tincture of iodine. The pain attending the operation is caused chiefly by cutting through and dissecting up the gum, and the trying in of the tooth. This may readily be controlled by the application of a small quantity of muriate of cocaine crystals to the parts for a few minutes, before the cutting is done.

Teeth have been successfully implanted in this way which have been three or four months removed from the mouth.—*N. Y. Med. Record*, July 9, 1887.

Roe (J. O.) on the Deformity Termed "Pug Nose" and its Correction by a Simple Operation.—The operation is performed as follows: We first deaden the sensibility of the interior of the end of the nose by cocaine, and then brightly illuminate this part.

If the tissue is to be removed from that portion where the mucous membrane is not too firmly adherent, the membrane should be dissected back, to be replaced after the operation.

The end of the nose is turned upward and backward, and held with a retractor by an assistant; then sufficient of the superfluous tissue is removed or dissected out to allow the nose to conform to the shape that we desire. Great care must, however, be exercised not to remove too much tissue, and also not to cut through into the skin, lest we may have afterward a scar or a dent in the external surface of the nose.

In some cases no after-treatment is required, but in others it is advisable to mould a saddle or splint, as it were, to the top of the nose, so as to make it, while healing, assume the shape we wish to obtain.

In some instances the large and unsightly end of the nose is not due to an excessive tissue, but to a malformation of the cartilages of the alæ, bulging outward with a corresponding concavity on the inside.

These noses can be very readily moulded into a handsome shape by cutting, with a small tenotomy knife, through these cartilages, in different places, sufficiently to destroy their elasticity. Then by inserting a silver or hard-rubber tube, of the proper size and shape, into the nostril, and conforming the saddle to the outside of the

nose, we have it encased in an outside and inside splint that compels it to conform to the exact shape we desire.

While performing this operation and moulding the nose into shape, we must not neglect to preserve the nasal passages free and unobstructed.

Thus far I have performed this operation on five persons, and all have been successful.—*N. Y. Med. Record*, June 4, 1887.

Surgery of the Spinal Cord.—We understand that on Thursday, June 9th, Mr. Victor Horsley removed a tumor in the dorsal region of the spinal cord from a patient under the care of Dr. Percy Kidd. The patient had been seen by Dr. Gowers, who had diagnosed a localized neoplasm, and suggested operative interference. The tumor measured about one inch and a quarter by half an inch; it was situated within the dura mater, and apparently grew from the ligamentum denticulatum of the spinal cord. It compressed the latter severely, causing violent spasms, pain, and complete paraplegia. Although the operation was necessarily prolonged, the temperature has never reached 100°, and the wound is now practically healed. The patient has already recovered some power over the bladder, and the spasms and pain are rapidly diminishing. We believe this is the first case of the kind in which an operation has been attempted.—*Br. Med. Jour.*, June 18, 1887.

Wells (Sir T. Spencer) on a Case of Porro's Operation.—This case the author believes to be the third one in the United Kingdom where both mother and child have been saved. The present case was not, as were the others, one of pelvic deformity but natural delivery was prevented by a large uterine tumor.

The patient was thirty-seven years of age. Seven months ago was examined for a supposed pregnancy of three months' duration. At that time the pelvis contained a large, hard tumor almost filling its brim and projecting low into the vagina. Pregnancy was not then diagnosed.

One month ago diagnosis of pregnancy made and patient referred to author who found pelvis blocked by solid tumor and os uteri out of reach. Two days later Porro's operation was done.

An incision five inches long was made in median line between umbilicus and pubes. The uterus was free but covered by layers of the broad ligament extending up from

the bladder. These were divided and pushed aside. The uterine cavity was then opened by a puncture, and as the liquor amnii escaped an aperture was torn in the walls of the uterus through which the head was drawn, and with slight traction the body followed. The child then cried loudly. The cord was divided between two cramps—placenta not removed. Incision was enlarged upward two inches, and through this the uterus with its tumor and both ovaries were removed. The base of the tumor was cut through by means of a wire and thumb-screw. The wound was closed without drainage, and mother and child were both in excellent condition at the time of the report.—*British Med. Jour.*, June 11, 1887. G. B. P.

Keetley (C. B.) on Transplantation by Exchange.—A female infant, four weeks of age, having a large hairy mole on its left cheek was brought to the West London Hospital for treatment. To excise this mole and replace it by a flap from the arm would have left a raw surface on the latter extending from the shoulder to the elbow, hence a new procedure was adopted.

An area the size of the mole to be removed was marked out on the left upper arm, and then dissected up with the fat and superficial fascia except on one side.

The face flap having previously been dissected up, excepting one side, the arm was carried up in front of the face, and the mole flap secured by sutures on the arm while the normal skin on the arm replaced the area on the face whence the mole had been removed. On the eleventh day the bases were detached and sutured to the arm and face respectively.

About one year after the operation there was on the face "an incomplete irregular ring of depressions or dimples and linear scars, these being slightly paler in color than the surrounding skin." The mole on the arm was movable and had not increased in size.

The author thinks this plan of preserving "healthy disfigurements" of the face, and exchanging them for healthy skin may be many times used advantageously.—*Lancet*, Feb. 19, 1887. G. B. P.

Watson (B. A.) on an Experimental Study of the Effects of Puncture of the Heart in Cases of Chloroform-Narcosis.—The results of sixty experiments on dogs were given in detail. The experiment consisted briefly in producing

death by chloroform-inhalation, and then, within from one to three or four minutes, an aspirating-needle was introduced into the heart through the chest-walls, the attempt being to reach the right ventricle. In the first fifty cases the chloroform was administered rapidly, and air was excluded as far as was possible. In the last ten the chloroform was administered slowly and with a large proportion of air. The first forty animals had already suffered some severe traumatic injury, while the last twenty were perfectly healthy animals. The punctures made in these sixty experiments were as follows: right ventricle, thirty-eight; left ventricle, six; right auricle, six; superior vena cava, three; inferior vena cava, two; apex of the heart, two; and not stated, one. The resuscitations were as follows: after puncture of the right ventricle, nine; right auricle, one. The first forty experiments gave only four recoveries, while the last twenty gave six. In only one of the sixty cases did the heart fail to respond to puncture, and in this instance the use of the needle was postponed for four minutes after the cessation of the heart's action, and one minute after breathing had stopped.

The following conclusions were reached:

First. Puncture of the heart, especially of the right ventricle, stimulates muscular contractions, and may be advantageously applied in the treatment of chloroform-narcosis.

Secondly. The best results are obtained when abstraction of blood from the cavity of the ventricle is combined with the stimulating effects produced by the entrance of the aspirator-needle.

Thirdly. The puncture of the right ventricle is a safer and more efficient operative procedure than the puncture of the right ventricle.—*Medical Times*, June 25, 1887.

Mills (T. Wesley) on Surgical Puncture of the Heart—A Warning.

—Referring to the experiments described in the preceeding paragraph, the author says that in 1884 Professor Kronecker, then of Berlin, ascertained, at first accidentally, that a needle thrust into the heart of a dog may arrest the ordinary ventricular beat, and substitute for it a "fibrillary" action, a sort of incoördinated movement of the muscular fibres, quite ineffective in expelling any blood from the organ. The auricles continue to beat as usual, and while they remain amenable to the action of the vagus nerve, the ventricles pass

wholly beyond its control. It was found that the vulnerable area was near the line of the left coronary artery, therefore near or in the septum of the ventricles, at about one third of the distance from the base of the heart.

From the fact that the puncture must be made in one isolated area, and that in a heart that has been long experimented on merely seizing it with the hand may originate the action in question, the writer considers its origin to be muscular rather than nervous.

The phenomenon in the dog lasts from seven to ten minutes, when the heart is arrested beyond the power of recovery. There is reason to believe that the heart of man would behave similarly to that of the dog. It is easy to understand why, if the area that is vulnerable is limited, or if the effect is dependent on the condition of the cardiac muscle, scores of punctures might be made without a fatal result. Indeed Professor Kronecker stated that his discovery explained why slight wounds of the heart had in some cases proved fatal, while much more serious ones, from the surgical point of view, had been comparatively harmless.

The author thinks that needle-puncture *is a remedy* would be a very dangerous proceeding; that while it might excite the quiescent organ to action, it might, on the other hand, cause a feebly beating heart, that would perhaps recover if left undisturbed, to become hopelessly incoördinate. *Med. News*, July 9, 1887. G. B. P.

Voigt (J. C.) on a Peculiar Deformity of the First Metatarso Phalangeal Joint.—The patient was an errand-boy, aged sixteen. For three months he had had severe pains in the metatarso phalangeal joint of the right great toe, and was on this account obliged to give up work. The joint was swollen, but there was no redness. The proximal end of the first phalanx was displaced upward, making a noticeable prominence. The toe was abducted markedly from the median line of the foot, and pointing downward.

Palliative treatment was tried unsuccessfully, and then the thickened and enlarged joint was excised, and with it fully two thirds of the phalanx was removed, the object being to get a rather large cavity filled with blood-clot. The flexor tendon was then cut through, and the wound dressed without sutures. At the end of treatment, about six weeks, the blood-clot was

found transformed to fibrous tissue, giving a "pretty movable and very useful substitute for a healthy joint."

Four months after he applied for treatment for a similar condition of the left great toe, which received the same condition.—*British Med. Jour.*, July 16, 1887. G. B. P.

PATHOLOGY.

Teissier (J.) on the Etiology of Diphtheria.—The author believes diphtheria to be an infectious disease whose germ is disseminated by means of atmospheric dust. He considers manure, rags, and straw excellent media for the culture of these germs which are frequently disseminated by chickens and pigeons. A moist atmosphere is propitious to the development of the germs and a chill renders the subject more likely to contract the disease.—*La Tribune Méd.*, July 3, 1887.

Milk Diphtheria.—Yet another instance has to be added to the list of those already recorded of diphtheria being caused by the agency of milk. And, although in the case of this outbreak at York Town and Camberley, the milk causation has not been so conclusively proved as in the analogous Hendon case, yet the circumstantial evidence is, if any thing, even stronger. Diphtheria became suddenly epidemic there in October of last year, and children of better class people were mostly attacked. Milk was early suspected, since most of the invaded houses got their milk from the same dairy-farm. It was at once seen that great contrast existed between the relative incidence of diphtheria on houses in relation with a particular dairy and that on others not suspected. For of the total 176 houses about which inquiry was made, 57 were invaded in October, and 84 per cent. of these got their milk from the particular dairy, and all were invaded in a period of ten days. And of 140 people who were ill of throat complaint in October, 88 per cent. were members of families having milk from this dairy, and 93 per cent. were attacked in the same ten days' period. It was next found that the incidence of the disease was three to four times greater upon the well-to-do than upon the cottagers and tradespeople. The latter used more milk, and stored that received

for longer time before finishing it. Cream by itself had not been especially infective; but there was a suspicion of the morbid power of skim milk, for there had been unusual incidence upon certain households using it. Intensity of attack among children seemed related to amount of milk consumed; but this relation was not observed in the case of adults. Thus far, then, the circumstantial evidence had been fully worked out in York Town and Camberley. But on proceeding to the farm and trying to get at the *vera causa* by probing into the condition of the cows and cognate matters, Mr. Powers was arrested by the fact (unfortunate to science) that, the different portions of milk having been mixed, no accurate differentiation could be made of their respective influence. Nothing in the condition of the farm or the cow-sheds could be pointed to as affording a satisfactory explanation of the outbreak, or of the means whereby the milk became infective, though every inquiry in this direction was made. There was much to be said of the view that two recently calved cows who began to supply milk at the beginning of the outbreak were concerned in its production. For, a little later than this, another cow was observed to have scabs on the teats like those seen at Hendon; and there seemed some ground for supposing that she may have been inoculated with an ailment, unnoticed to them, akin to the disease observed in the case of the Hendon cows.—*Med. Press*, May 25, 1887.

Scarlatina Conveyed by Milk.—Dr. Klein believes that the milk of scarlatinous cows may convey the infection in two ways: both as a secretion of a diseased animal, and from the mingling in it of contagious particles brought off from the udder by the hands of the milker. He finds that a temperature of 85° C. (185° F.) will destroy the micrococcus of scarlatina, and hence recommends that the milk be heated to that point, though not necessarily that it be boiled, before it is consumed.—*Boston Med. and Surg. Jour.*, June 30, 1887.

Neph (A. A.) on Petechiæ after Pneumonia—Report of a Case in Private Practice.—On Jan. 12, 1887, I was called in to see O. H., aged four and a half years. Family history: Father rheumatic; mother healthy, but has two or three small lipomata. No *specific* history on either side. Boy has good food and

water, and lives in a healthy locality. On examination I found pneumonia of right lung, which progressed so well that I discharged him Jan. 23d. During the progress of the case there was delirium, and extreme nervousness, as manifested by screams and convulsive jerkings, when the patient was touched, or when there was the least noise in the room. I regarded the case as one of cerebral pneumonia. On Jan. 23d I noticed ten or twelve spots. They were about the color of what is ordinarily termed a "blood blister," and they caused no discomfort, had no surrounding redness nor swelling, and as there were no indications of hemorrhagic diathesis, I paid but little attention to them, thinking they would disappear of their own accord. On Jan. 27th the father of the boy came to my office, saying his son was covered with spots, which he termed "boils." They were larger, elevated and darker than before, and now caused considerable *itching*, but no pain. I gave him the following:

R Tr. ferri chlor. f ʒj
Liq. pot. arsen. f ʒjs
Aquæ q. s. ad. f ʒj

M. Sig.—Half a teaspoonful in water after meals and at bed-time.

For the itching I gave the following:

R Acid carbolic grs. xx
Acid tannic grs. x
Glycerinæ aa ñ. ʒj

M. Sig.—Apply on lint as needed, to relieve itching.

Jan. 29th his father requested me to go and see him, saying that while some of the spots were drying up, others seemed to be forming. The itching was relieved. On my arrival, I found the boy sitting up playing with his brother. He said his legs hurt him when he walked. His pulse was 92; his temperature 99.2° (Fahr.); his respiration 24. His appetite was voracious, and his bowels regular as to frequency, but the stools looked like a mixture of grumous blood intimately blended with mucus. Upon inquiry I found that the stools had presented this appearance for two days, but as it began about the time of the prescribing of the iron mixture the family thought its appearance was owing to the medicine. That it was not, is shown by the fact that it disappeared during the continuance of the iron.

I will now attempt to describe the spots, though they should be seen to be appreciated. They varied in size and color

according to location. Those on the face, scalp, trunk, and in the mouth, were about one line in diameter, but not elevated. They were of a dark-red color, if of more than twenty-four hours duration, more recent ones being paler. Those on the extensor surfaces of the limbs, especially on the forearms and legs, were about four lines in diameter, and about two and a half lines high, above the surrounding surfaces. The large ones were of the color of venous blood, afterwards getting darker. Upon cutting into two of the larger spots there oozed from the more recent ones a little bloody serum. The other peeled off in layers like the coats of an onion, finally disclosing a small coagulum, dry and dark. These large ones, in form, resembled half a filbert placed with its cut surface on the skin. There must have been at least fifty on the head and face, while on his entire person there were fully three hundred. The patient said the cutting caused no pain, but tickled his leg.

The treatment already mentioned was continued, and in about a week new spots ceased to appear, but those already formed still remained. To-day (June 30th) the boy is enjoying good health. The spots, though not so prominent, are still there, and of a darker color, except those on his head and face, where there is only a pink stain remaining to show their former site. Those in his mouth have entirely disappeared.

In conversation with a number of physicians, I have found but one, Dr. Ridgeway, of Galvin, Ohio, who has seen such a case. Neither do I remember having seen such a case recorded. In Dr. Ridgeway's case, the administration of tr. ferri chlor. sufficed to limit the occurrence of the spots, as it did in my own, but they had not entirely disappeared in a year from their occurrence.—*Med. and Surg. Reporter*, July 23, 1887.

Kinnicutt (F. P.) on Atrophy of the Gastric Tubules: its Relation to Pernicious Anæmia.—The speaker gave the histories of two cases, in which the typical symptoms of pernicious anæmia were well marked. At the autopsy in each of these cases, nothing special was found in any organ but the stomach. The inner surface of the organ was smooth. Microscopical examination was made of numerous sections removed from different parts of the stomach. Throughout a large extent no trace of gastric tubules was found. In some parts, the more superficial portions of the

tubules could be found, but the deeper portions could nowhere be made out. There was also seen a peculiar hyaline substance, in the shape of tubes and of drops. Numerous irregular cells were seen near the surface of the mucosa. The author thought that, in this lesion of the stomach, was to be found the explanation of a certain number of cases of pernicious anæmia.—*Bost. Med. and Surg. Jour.*, June 30, 1887.

Taylor (R. W.) on a Rare Form of Septicæmia Following Internal Urethrotomy.¹—The operation was performed in 1878 by a colleague, and the case was seen by Dr. Taylor in consultation. The occurrence of the accident, complicating urethrotomy, is unique in medical literature, and this consideration, together with the fact that the form of septicæmia is little known and only indifferently described by English and American writers, prompted the preparation of the paper. The patient was a perfectly healthy man, aged twenty-eight, who had a tight stricture of the bulbomembranous junction, which was incised by means of Maisonneuve's instrument. The operation was performed with all care. Within twenty-four hours severe pain attacked the perineal region, and soon a reddish, boggy appearance was observed. Then the inflammatory action extended, and presented marked features. The integument became œdematous, and a distinct emphysematous crackling was felt when pressure was made on the parts. As this rapidly extended, large brown patches of skin developed, which felt as hard as the rind of ham. Beside these there were large ecchymotic spots and deep blue-black lines which were caused by congestion and destruction of the veins. This condition extended over the whole body, which, during life, was much enlarged by the œdema and gas in the subcutaneous tissue, and after death the body became rapidly swollen beyond recognition and to fully twice its normal size, and was a deep purple, gangrenous mass, covered with large bullæ, and emitting a horrible stench. Death took

¹ The *Med. Record*, June 14, 1887, says: "A case of gaseous gangrene affecting the subcutaneous cellular tissue was reported recently by Dr. H. C. Dalton, before the St. Louis Medical Society. A similar case was observed in Bellevue Hospital in April, 1878, and reported by Dr. E. G. Janeway, to the Obstetrical Society, if we remember correctly. The case occurred in a woman who had aborted at three and a half months."

place eighty-seven hours after the operation. The subjective symptoms were rapid pulse, tremulous action of the heart, progressive and distressing dyspnoea, intense restlessness, utter agony and despair. The temperature at first rose, then fell below normal.

The disease was not accurately known until 1870, although many cases of it had been reported, particularly as occurring in the army, navy, and crowded hospitals. The cases were mostly epidemic. It started on the limbs generally, most frequently on the legs. It had been called many names, but Dr. Taylor referred to the one proposed by Mollière, *septicémie gazeuse foudroyante*.

Reasons were given in support of the view that the disease caused by a specific septic microbe. The only treatment is thorough amputation of the part in which the septicæmia begins, if that is practicable. — *Med. News*, May 28, 1887.

Greenough (F. B.) on the Comparative Frequency of the Chancroid.

—He referred to the marked individuality that was given to the chancroid by the text-books, in spite of which the great difference in the statistics by different observers would show that they must have used a different system or classification. Throughout this divergence of statistics, however, two facts appeared. First, that this lesion had diminished in its relative frequency to the true chancre with the exception of two periods in Paris, that is, during the war and siege (1870–71) and during the exposition (1875), and that it occurred more frequently in hospital than in private practice. Dr. Greenough's records at the Boston dispensary from July 1, 1873, to March 31, 1887, gave a total of 1,493 cases, of which 391 were chancroids, 219 true chancres, 931 doubtful, and 52 cases are herpes progenitalis; making the chancroid stand in proportion to other lesions in the ratio of one to three. These records were not satisfactory, as they showed only the diagnosis made at the time of the first visit. In private practice, out of 100 cases seen, ten were chancroids, sixty-three were true chancres, thirteen were doubtful, and fourteen were herpes progenitalis, being a ratio of one to ten. The diagnosis in these cases were much more reliable. Both sets of cases showed diminution in the frequency of chancroid. — *Bost. Med. and Surg. Four.*, June 2, 1887.

Hardaway (W. A.) on the Nature of the Chancroid. — His conclusions, may be summarized as follows :

1. That syphilis is a germ disease.
2. That the virulent chancroid is due to inoculation with purulent secretions from syphilitic subjects; and that, when thus inoculated upon virgin soil, syphilis would inevitably ensue if the germ upon which its contagiousness depends did not, in some way, suffer destruction by the suppurative process probably by the accompanying elevated departure.¹ — *St. Louis Cour. of Med.*, June, 1887.

TOXICOLOGY.

Putnam (J. J.) on the Frequency with which Lead is Found in the Urine, and on the Symptomatology of Chronic Lead-Poisoning. — From the examination of the urine in eighty-six cases, the following conclusions were presented :

1. It is probable that lead may cause neurasthenic symptoms, which may exist for a long time without other signs of poisoning.
2. The same is true of fine muscular tumor, especially if associated with debility.
3. The most important conclusion is, that lead seems to cause, occasionally, a greater or less degree of the symptoms classed as spastic paraplegia, instead of the usual type of paralysis, with atrophy and loss of the deep reflexes.
4. Additional evidence is furnished of the importance of suspecting lead as a cause of vague cerebral symptoms, such as are often due to syphilis.
5. In one case of epilepsy in a person not predisposed, and where the probable first attack occurred at the age of twenty-five, besides the discovery of lead in the urine, there was a slight weakness and impairment of electrical reaction of the long extensors of the fingers.

Two cases of ataxia, with extensive muscular atrophy and other signs of peripheral neuritis, were reported, probably due to lead. — *Bost. Med. and Surg. Four.*, June 30, 1887.

¹ It may be that the failure to inoculate syphilis upon the lower animals is due to a difference of temperature between them and man, offering an analogy to that which occurs, according to Warlomont, when variola is transplanted to the horse and cow.

Hun (H.) on Cases of Sewer-Gas Poisoning.—He thought it probable that the following diseases may result from sewer-gas poisoning: Vomiting and purging, separately or combined; general debility, fever, sore throat of a diphtheritic type, neuralgia, and perhaps also myelitis of the anterior horns. These conditions are frequently combined. Fever is frequently associated with the other symptoms. There is one group of symptoms which is almost always present, and that is loss of appetite, extreme prostration, and pain in the head. When this occurs as a chronic condition we are justified in suspecting that the patient is suffering from sewer-gas poisoning. He reported in detail twenty-nine cases.

Dr. W. W. Johnson, of Washington, in discussing this paper, said that the theory of sewer-gas poisoning has gradually taken the place of malaria as the supposed cause of many obscure conditions, just as malaria superseded the hepatic origin of disease. The theory which attributes many of these conditions to the presence of sewer-gas has not been proven. In an examination of a number of men working in the sewers of this city it was found that they were more healthy than those who worked above ground, and the same observation has been made in other places.—*Med. News*, June 18, 1887.

Is Sewer Air Noxious.—At the request of a select parliamentary committee which in 1886 was appointed to inquire into the drainage of the House, Professor Carnelley and Dr. Haldane, of University College, Dundee, have made careful experiments upon the air of sewers. Their results were communicated to the Royal Society at its meeting on June 16th last, and they are certainly surprising. Examining it by various methods, they were unable to discover that it was much worse than the atmosphere outside, and in some respects it compared favorably with the air of close rooms. Comparing the air of the sewer with the air outside it at the same time, they found that the sewer air contained about twice as much carbonic acid and about three times as much organic matter as the fresh air, but much fewer micro-organisms. In small and ill-ventilated houses they found more carbonic acid, more organic matter, and far more micro-organisms than in the sewer air they examined; so that if these experiments were to be taken as final and conclusive, the inhabitants of

a small room would improve their sanitary position by living in the atmosphere of a sewer. But, of course, the experiments are not conclusive, and the authors have done wisely in founding no sanitary conclusions upon them. They will even be dangerous if they lead any one to regard with indifference the presence of what we must continue to consider as an insidious enemy. In regard to organic matter and micro-organisms, it is the quality and not the quantity which is of importance.—*Lancet*, July 2, 1887.

Girling (J.) on Poisoning by Pennyroyal.—About an hour after the drug had been taken I found the patient (a woman aged 40) in an extremely collapsed condition. The face was pale, cold, and bedewed with beaded sweat, and the hands and feet were cold and clammy. She lay apparently unconscious, but could at first be roused by shaking and shouting to her, rapidly sinking, however, into a state of profound coma. The pupils were normal in size, and responded to light. The action of the heart was exceedingly weak, irregular, and fluttering, the pulse at the wrist being scarcely perceptible. The first cardiac sound was almost inaudible, while there was distinct reduplication of the pulmonary second sound. There was jactitation and feeble retching, with much salivation, but no vomiting and no purging. Temperature, 97° Fahr. The breath smelt very like peppermint. The treatment adopted was as follows: First I gave her three-quarters of a tumblerful of water, followed immediately by a hypodermic injection containing one-fifth of a grain of apomorphine. This latter quickly produced the desired effect, the vomited matters having a strong peppermint-like odor. After the vomiting the patient seemed about to die, and having no ether with me, I administered brandy hypodermically. The result of this was excellent; the heart sounds at once began to improve in tone, and the pulse in force, and in twenty-four hours the patient was practically well. Thus the symptoms taken together seem to point to severe cardiac depression approaching to paralysis, and appear to indicate that pennyroyal should be classed among the narcotic heart poisons. It transpired afterwards that the woman had taken ʒj of the essence of pennyroyal (which she had obtained from a chemist) and which is composed of ʒj olei pulegii to 3 vii of spirit.—*Br. Med. Jour.*, June 4, 1887.

OBSTETRICS AND DISEASES OF WOMEN.

Harris (R. P.) on the Progressively Increasing Mortality of the Cæsarean Operation in the United States.—It is one thing to operate as soon as the proper time arrives, and quite another to do it under a conviction that this time has in all probability passed many hours, some days, or even a week or two. There would appear to be an intimate connection between the living of the foetus and the success of the operation, an association which has also been very marked in the Säger cases. If our obstetricians had as good a knowledge of pelvimetry as prevails in the maternities of Austria, France, Germany, and Italy, there would be much less delay, and fewer attempts to deliver, either by forceps or craniotomy, in cases of pelvic deformity, or other forms of obstruction. If the pelvic space is first accurately ascertained, its measure of diminution should at once determine the possibility or impossibility of delivery by version, the forceps, or craniotomy. It is certainly bad practice to fail first in craniotomy, and then be forced to deliver the destroyed foetus, by opening the abdomen and uterus, with the increased risk to life engendered by the futile intermeddling.

The declination of the family is sometimes given as a reason for delay; but this objection to the use of the knife would not hold, if the parties in interest were made to understand that the operation was absolutely requisite, and that to delay was to lose the patient. Reduce the mortality, by promptness, decision, and the best improvements in operating, and the dread of the knife will diminish as success becomes more frequent. Properly educate the obstetrician, and the surgeon will soon show what measure of fatality truly belongs to his part of the work. We are certainly justified, from the Säger successes, in our claim that *per se* the Cæsarean operation is far less fatal than it has been made to appear in the United States.—*Med. News*, Oct. 16, 1886.

Johnson (J. T.) on the Cæsarean Section.—In the performance of the Cæsarean operation, I submit a few essential rules:

1. At once carefully determine the de-

gree of obstruction, and operate early in labor—*i. e.*, as soon as the os is sufficiently dilated to permit drainage of the lochia, and before the rupture of the membranes. Delay is fatal.

2. Operate with full antiseptic precautions; for, of all abdominal operations, no other demands so absolutely that asepsis should be secured; but the spray over the abdomen is unnecessary.

3. Control hemorrhage by compression of the cervix, either manually or with rubber tubing, but preferably manually.

4. Introduce numerous deep and superficial sutures so as to approximate accurately the muscular walls and serous surfaces of the peritoneum; but do not carry the sutures into the endometrium. The removal of a section of the muscular wall is unnecessary.

5. Carefully protect the peritoneum from contact with fluids, and make a careful toilet of that membrane, if perchance it has been soiled.

6. Administer ergotine hypodermically at the beginning of the operation.—*Four. Am. Med. Ass'n*, Feb. 12, 1887.

Is Dentition a Cause of Disease?

Dr. G. W. Cook, of Washington, D. C., in an instructive paper on the above subject, among other things says: From observation and thought, however, I am persuaded that nature has not been at fault, but the error lies in assigning a cause for the disease, and dentition is a most convenient scapegoat. I know that this opinion is at variance with the popular idea, as well with the bulk of the practitioners of medicine as with the laity, and the purpose of this paper is to stimulate thought upon the subject, that nature may be justified and the ailments of infancy assigned to their true causes.

Taking into consideration the facts that certain atmospheric conditions, bad hygiene, and errors in diet will produce the same kind of diseases in the adult as in the child, and that dentition is a *necessary* and *inevitable* physiological process, is it not more reasonable to attribute the diseases of infancy to other than a *physiological* cause?

If you will consider this subject deliberately, helpless infants will be spared much suffering, and many lives will be saved. But so long as the physician inculcates the doctrine that the evolution of the teeth is

a cause of disease, the laity will accept that doctrine, and anxious mothers will stand idly by *waiting for the coming of the teeth*, and hoping the trouble will soon be over. But, alas! precious time has been lost, and too often the penalty of such neglect is the death of the child.—*Amer. Four. Obstet.*, June, 1887.

Caldwell (C.) on Enlarged Thyroid as a Cause of Transverse Presentation.—The patient was a woman of 35. Her first seven confinements were normal, and she was attended by a midwife. Seven years ago the left lobe of the thyroid gland began to enlarge during gestation, but caused neither pain nor dyspnoea. Three years ago, during her eighth pregnancy, the right lobe began to enlarge, and increased in size very rapidly, producing both pain and dyspnoea, compelling her to take a semi-recumbent position at night instead of a horizontal one. During the last three months of gestation she sat bolstered up in bed at night. This posture, which she was obliged to take whenever she sat down, during the day as well as the night, produced a continued pressure on the fundus of the uterus, changing its long axis from vertical to an oblique or transverse direction. Of course the long axis of the foetus must coincide with that of the uterus, and the continued pressure on the breech or head, according to the end of the foetal ovoid at the fundus, would force it into an oblique or transverse position, and also throw the lower end of the foetus out of the pelvis and above its brim. The same position of the mother is maintained during labor as during the last three months of pregnancy, hence the foetus remains in the same oblique or transverse position, and the lower end of the foetal ovoid cannot descend below the pelvic brim.

The author of this article attended the patient in the three confinements which occurred after the goitre appeared, and in each the presentation was transverse. In the first two labors a midwife had so complicated things that the doctor was compelled to deliver a dead foetus. In the last confinement, where the doctor had full sway, he delivered a living child.—*Maryland Med. Four.*, July 23, 1887.

Farlow (J. W.) on an Analysis of 141 Cases of Pregnancy with Reference to the Diagnostic Value of the Blue Color of the Vagina.—The author tabulates his cases as follows :

How Long Pregnant.	No. Blue Color.	Suggestive.	Characteristic.	Total.
6 weeks .	1	1		2
2 months .	11	10	1	22
2½ " .	5	3		8
3 " .	12	5	11	28
3½ " .	1	1	1	3
4 " .	1	8	10	19
4½ " .	3	4	7	14
5 " .		1	15	16
5½ " .		1	14	5
6 " .	1		11	12
6½ " .			1	1
7 " .	1		3	4
8 " .		1	6	7
	36	35	70	141

In this connection he has examined the records of about two thousand gynaecological cases. Among these cases, there have been, of course, fibroids, ovarian tumors, large ovaries, uterine displacements of all kinds; in fact, the cases that are usually found among so large a number of cases, but in only four was the color in the least characteristic.

The author also had occasion to notice its absence in many cases of women who supposed themselves pregnant, but who were not so. He has examined for it with the patient on her back, and with his fingers has separated the folds of vagina, so as to get a good view, particularly of the anterior wall of the vagina, and in some cases has used the speculum.—*Bost. Med. and Surg. Four.*, July 21, 1887.

French (G. F.) on the Chief Source of Danger in the Use of the Uterine Sound.—The prevailing opinion of the medical profession is that the chief danger to guard against in 'probing or sounding the uterus is traumatic lesion from incautious handling of the instrument. Emmett says many a poor woman has endured years of bad health from the carelessness of her physician in overlooking a latent cellulitis, which became re-kindled by the unskilful use of the probe or sound. Surgeons like Tait and Mundé are so absolutely clean in their methods of doing surgical work, that no septic results occur, though they are so unconscious of septic danger as to ignore its existence in their writings. Mundé sounded the uterus 5,000 times without a catastrophe, which only proves that he practises better than he preaches; a criticism equally true of the great pyo-salpingist of Birmingham. I would not detract one iota from the importance of delicate manipulation in

exploring the uterine cavity, but I maintain that the danger from traumatic lesion is completely overshadowed by that from septic infection.

Nöggerath's doctrine of latent gonorrhœa is just beginning to be fully recognized, but instead of being an isolated, exceptional fact, it is one of a large group of facts which illustrate a general principle. From the researches of Hart, Lindgren, and Leopold, it has been demonstrated that the intra-uterine mucous membrane is really a lymphatic gland, or a lymphatic surface intersected with glands and blood vessels. To Hart belongs the distinction of being the first among English-speaking writers to call attention to this comparatively unrecognized danger. He says, "The great dangers to the patient from the passage of the uterine sound are abortion and abrasion of the mucous membrane with absorption of septic matter, and resulting cellulitis and peritonitis. Two cases of this nature are reported by Sânger, of Leipsic. Manifestly a gonorrhœal pyosalpinx might be communicated as readily by an infected sound as by the extension of the disease from the vagina. So, too, a septic pyo-salpinx, non-gonorrhœal, whether derived from the virus of erysipelas, pyæmia, diphtheria, or scarlet-fever, may be carelessly transferred from the gynecologist's hand to the sound, and give rise to a pelveo-peritonitis with more or less systematic infection."

Fritsch says, "Always before introducing the uterine sound dip it into a three or five-per-cent. solution of carbolic acid, even though properly cleansed directly after its previous use.—*Med. and Surg. Reporter*, June 18, 1887.

Chéron on the Treatment of Eczema at the Menopause.—He orders in water, with meals, a coffee-spoonful of the following solution :

℞ Arseniate of soda gr. v.
Distilled water 3 v.

Twice a week a purgative dose of the citrate of magnesia is to be taken, followed by vegetable soup.

He has applied to the eruption every evening an ointment of—

℞ White precipitate 1 part.
Vaseline 20 parts.
Essence of roses q.s.

Every eight or ten days he injects subcutaneously 6–10 drops of the following solution :

℞ Nitrate of pilocarpine . . gr. 1½.
Distilled water gtt. lxxv.

—*Rev. Méd. Chir. des Mals. des Femmes*, June 25, 1887.

Chéron on a Hemostatic Mixture.

—In operations upon the cervix, vulva, and in the removal of vegetations from the vulvo-anal region, the surgeon often feels the need of an entirely reliable hemostatic. In such case Chéron applies on lint the following mixture proposed by Pavesi :

℞ Tannic acid 5 parts.
Benzoic " 5 "
Glycerine 25 "
Alcohol 25 "
Sulpho-phenic acid¹ . . . 25 "
Rose water 200 "

The benzoic acid is dissolved in the alcohol and glycerine, and the tannin in the alcohol.—*Rev. Méd.-Chir. des Mals. des Femmes*, June 25, 1887.

Van de Warker (E.) on Stricture of the Urethra in Women.—I make use of graduated steel sounds, the same that I used when in general surgical practice to treat male stricture. The action is twofold—to dilate and to cause gradual absorption of the constricting exudate. In strictures of large size, forcible dilatation or divulsion may be used : but I doubt the utility of this method in rigid strictures of small dimensions, as I believe it would be found necessary to supplement the operation by the use of the sound to prevent contraction. The treatment, made two or three times a week, extends over a considerable length of time—from two to three months ; but the relief given to the patient early by the use of the sounds is very satisfactory. As dilatation of the urethra is no more important than the absorption caused by their use, the latter implies a more or less prolonged treatment.

I believe any one can verify my position upon this subject by the habitual examination of the urethra with the exploratory bulbs in every case of pelvic disease that presents itself for treatment. The usual practice is not to explore the urethra, except when urinary symptoms are present, and then either by the sound or by some form of urethral speculum. My own experience is that one may learn more by the thorough way in which you can *feel* the conditions of the urethra by a properly

¹ Made by mixing two parts of sulphuric acid and one part of phenic acid, and warming some minutes over a sand bath.

selected bulb than by seeing. Speculum or endoscopic examination of the female urethra is a very unsatisfactory method compared to the touch. Here, as in other pelvic diseases of women, the gynecologist ought to make his diagnosis by the touch. As women are extremely sensitive in the urethra, cocaine should be used both in examination and treatment. In the examination the solution ought to be employed of full strength—5 per cent.—as the passage of the bulb is much more painful than that of the sound.—*Med. News*, July 16, 1887.

MISCELLANEOUS.

Scirrhus at Sixteen.—Dr. Geo. Lumis, of Cincinnati, reported to the Cincinnati Academy of Medicine, June 24th, the case of a young girl, aged 16, who had suffered for five or six months from a slight pain in the sacral region; had not had her monthlies for four or five months, but who had been able to keep at her work, that of a waiter in a restaurant, until a little over three weeks before her death, when the doctor was called to treat for obstinate constipation. The abdomen was distended to the size of a nine-months' pregnancy, and it was quite impossible to make out any of the abdominal organs. The stomach disturbances were quite unimportant and the urine was normal. Examination per rectum and vagina was made and a stricture of the rectum made out. The girl passed a few tar-like stools and died. She was completely constipated for five weeks.

A committee, after a careful macroscopic and microscopic examination, reported that they found a scirrhus of the rectum involving also the mesentery and both ovaries. In fact, there was present a miliary carcinoma, which is a condition comparable to miliary tuberculosis. — *American Lancet*, July, 1887.

Poore (G. V.) on a Case of Spasmodic Torticollis Probably Caused by Cerebral Lesion.—The case is found in the *Transactions of the Clinical Society of London*. The patient was thirty-six years old; had been suffering from violent spasmodic torticollis for nearly six months, division of the sterno-mastoid muscle did not relieve the condition. On the left side of the head (the head was twisted towards the right shoulder), immediately over the

situation of the posterior part of the superior and middle frontal convolutions was a scar, the result of an injury many years previously, which at the time had "half-stunned him." There was an undoubted history of syphilis, and the patient, prior to the onset of the torticollis, had suffered from headache, referred to the neighborhood of the scar, and from occasional attacks of giddiness. The torticollis almost completely disappeared under the administration of mercury.—*Brit. Med. Jour.*, May 21, 1887.

BOOK NOTICES.

The Vest Pocket Anatomist.—By C. Henry Leonard, A.M., M.D., Detroit. The Illustrated Medical Journal Co., 1887.

This little volume is a sexto-decimo book, "founded upon Gray," and containing eighty-five illustrations reproduced in an excellent manner, either full-sized or slightly reduced, from the well-known plates in Gray's Anatomy. The diagram showing the formation of the brachial plexus is not the one given in the last edition of Gray, which agrees very nearly with that of Schwalbe.

To a student it would be of little use in the preparation of a recitation, but in the dissecting room it could be used advantageously, as it could also be used by one thoroughly posted in anatomy who wished to be reminded of certain points for the time forgotten. The points given about the bones, muscles, nerves, and arteries are very briefly but correctly stated.

On Lupus Erythematosus or Bat's-wing Disease.—By Balmanno Squire, M.B., Lond., &c. J. & A. Churchill, London.

In a fasciculus of four large pages illustrated with cuts showing the microscopical appearances, and a large colored plate of a case, of which the history is given, Dr. Squire presents an interesting account of that disease which Hebra named *Seborrhoea Congestiva*, and afterward adopted for it Cazenave's designation of *Lupus Erythematosus*.

The author suggests for the disease the name of *Vespertilio*, and regards it as primarily and essentially a lesion of the sebaceous glands.

The treatment he adopted in the case reported was that known as "erosion," using a sharp spoon devised by himself which differs somewhat from that of Volkmann.

Of the remedies employed to promote absorption of the lesions, he prefers a soft-soap solution. Among the cauterizing agents he chooses fuming nitric acid, and of mechanical procedures erosion has his preference.

Transactions of the N. Y. State Medical Association for the year 1886.—Vol. III., Edited by Alfred L. Carroll, M.D., Republican Press Association, Concord, N. H.

This handsome volume of 601 pages reflects great credit on its contributors by its contents, and on its Editor and publishers by its neatness. Its articles are of the highest order, but as many of them have

been abstracted before in this Journal, it is only necessary to commend them all in a general way.

It contains portraits of three distinguished recently deceased members, Austin Flint, Frank H. Hamilton, and Jno. P. Gray. It contains also a list of the officers and council; a list of the fellows, alphabetically and by district and county, and a full index.

Elementary Microscopical Technology.—A Manual for Students of Microscopy in three parts. Part I. The Technical History of the Slide, from the Crude Material to the Finished Mount. By Frank L. James, Ph.D., M.D.

The first part of this work, now before us, is a complete résumé of the methods now employed in cutting, staining, and mounting material for microscopical examination.

Although familiar with the subject matter of this work from other sources, we believe Dr. James has rendered a valuable service to microscopy, in collecting from numerous works on the subject, an excellent compend on the Technical History of a Slide.

The excellent order and classification of the subjects dealt with, the perspicuity with which they are presented, should command a wide circulation for the work.

We shall look with interest for the second and third parts of "Microscopical Technology," by the same author.

FRANK FERGUSON.

BUSINESS NOTES.

Uterine Tonic.—Alettris Cordial (Rio) is, without doubt, an excellent Uterine Tonic. I am more than pleased with the satisfactory results produced by its use in cases of uterine troubles which have come under my observation. I regard it as an invaluable medicine.

H. T. Cox, M.D., Mobile, Ala.

Lactopeptine.

Philadelphia, Pa., May 30, 1878.

I have found great satisfaction in the use of Lactopeptine, and have ordered it frequently in cases of dyspepsia, especially where there is want of tone and defective secretion.

JOHN H. PACKARD, M.D.,
Pres. Pa. Co. Obstet. Society; Surg. Episcopal and Women's Hospital.

Horsford's Acid Phosphate.—Dr. T. F. Breck, Springfield, Mass., says: "I consider Horsford's Acid Phosphate very superior in diseases pertaining to the nervous system, and am very much pleased with results."

Iron-Alum Mass.—The Seven Springs Iron-Alum Mass, is, in my opinion, the best iron preparation known to the profession.

L. J. BURTON, M.D.,
Blossom Prairie, Texas.

Cod-Liver Oil.—Write to Scott & Bowne, 132 S. Fifth Ave., New York, for

samples of their goods and mention THE ANALECTIC. See ad.

Gurney Cottage.—Now is the time to send your patients to the country. The above cottage, situated at Atlantic City, N. J., offers special inducements to physicians. See ad.

McArthur's Hypophosphites.—It will pay you to try McArthur's Syrup Hypophosphites Compound (chemically pure) in cases of Phthisis, Nervous Diseases, or Wasting Diseases of the System, and you will be well pleased with results. Report your experience with them to McArthur Hypophosphite Co., Boston, Mass., and mention the ANALECTIC. See ad.

Crystalline Phosphate.—*Provident Chemical Works, St. Louis, Mo.:* GENTLEMEN—I herewith state with pleasure that I have found your Crystalline Phosphate an excellent tissue food, forcing the nerves, and an invigorating, pleasant, and palatable drink. Respectfully yours,

HENRY HUG, M.D.

Detroit, Mich.

Colden's Liquid Beef Tonic.—"I have used with flattering results, 'COLDEN'S LIQUID BEEF TONIC,' as a food in a variety of cases—notably in cases of gastric irritability, and such acute inflammatory conditions of the gastric mucous membrane." S. H. FRAZER, M.D.

St. Louis.

Abdominal Supporter. Attention is called to Flavell & Brother's new advertisement of an Abdominal Supporter with Uterine Cup appended. See ad. They have reduced the price of this abdominal supporter which is sold either with or without the cup. Send for illustrated catalogue of their goods and mention MEDICAL ANALECTIC.

Lactated Food. Walter Woodman, M.D., Portland, Me., writes: "Your Lactated Food has given me great satisfaction in a recent case where a babe had been weaned at fifteen months. Other foods invariably caused irritation, and a return to Lactated Food as invariably allayed the symptoms. This was tried not once but a number of times. The result I attributed to the conversion of the insoluble starch."

Milk of Magnesia.—Special attention is called to the advertisement of Phillips' Milk of Magnesia on top of title-page.

X

THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

VOL. IV., No. 9.

September, 1887.

WHOLE No. 45.

LEADING ARTICLES.

Claiborne (J. H.) on Stenocarpine, a New Local Anæsthetic.—During the past fall Mr. M. Goodman, V.S., in travelling through West Feliciana Parish, La., had occasion to apply a poultice to the fetlock of one of his horses. Having none of the customary means at hand with which to make it, he raked together a number of leaves from the ground, and having saturated them with hot water, applied the mass as a poultice to the inflamed part. After the swelling had arrived at the proper condition, he made a free incision into the part without the horse giving any evidence of pain. It occurred to him that the leaves might have anæsthetic properties; and a few weeks after, having occasion to open an inflamed bursa on the elbow of another horse, he made a similar poultice, applied it as before, and again made the incision without any pain to the animal.

Dr. Allen M. Seward, of Bergen Point, N. J., having obtained, through Mr. Goodman, some of the leaves, made an analysis of them. He found a number of constituents, among them an alkaloid, and having excluded all others as the anæsthetizing element, concluded that this virtue lay in the alkaloid. He made a two per cent. solution of the alkaloid, and settled the point by obtaining local anæsthesia in a cat's eye with several drops. Mr. Goodman informs me that the tree is known in the locality mentioned as the Tear Blanket Tree.

It grows to the height of thirty-five to forty feet, with a diameter to the bole of about eighteen inches and a spread of foliage of about thirty to thirty-five feet. The leaves resemble those of an acacia. The bark is smooth. From the ground up the tree is furnished with clumps of forked spines or thorns, the parent spine springing at right angles from the bough or trunk.

Though Mr. Goodman is a native of the region, he has never seen the tree blossom. As fruit it bears pods eight or ten inches in length, flat and slightly curved, containing seeds and a viscid juice.

The spines are very tough and highly polished, and the wood is extremely tough. It grows in clumps and singly, and is abundant in Louisiana.

From the likeness of the tree to the acacia stenocarpa Dr. Seward dubbed the new alkaloid stenocarpine. It would have been better, however, to withhold the naming of the alkaloid until the botanical name of the tree had been known.

Through the kindness of Dr. Seward I was put into possession of two drachms of a two per cent. solution of the alkaloid.

The results obtained under its use are appended below.

On the afternoon of June 25th two drops of an aqueous solution of the alkaloid were instilled into the eye of a rabbit.

In five minutes there was insensibility of the cornea and conjunctiva, palpebral and bulbar, so that the corneal epithelium could be abraded and the conjunctiva seized and twisted with forceps without any evidence of pain or sensation from the rabbit.

In ten minutes there was the same insensibility, with slight dilatation of the pupil. The palpebral fissure seemed wider than at first.

In fifteen minutes the palpebral fissure was markedly widened, the insensibility was the same, the dilatation of the pupil increased.

In twenty minutes the dilatation of the pupil was *ad maximum*, the anæsthesia the same; no change in the width of the palpebral fissure.

At the end of forty minutes there was slight sensibility of the conjunctiva, but complete anæsthesia of the cornea. Dilatation still *ad maximum* and width of palpebral fissure same.

Throughout the period of observation, that is, after anæsthesia was established, the cornea presented the same dry, glazed appearance as is observed in cocaine anæsthesia.

In thirty-six hours after the last observation, the dilatation of the pupil was still *ad maximum*, the anæsthesia had entirely disappeared, and the palpebral fissure was normal in width. No blanching of the conjunctiva was observed at any time.

Two drops were placed also on the inner surface of one of the animal's ears, and in ten minutes the surface of the ear covered by the drops could be pierced by a scalpel without a cry or movement from the animal. Multiple punctures in the surrounding tissue elicited abundant evidence of pain. As no untoward symptom appeared at the end of two days, I suggested to my friend, Dr. Allis, of Plainfield, N. J., to allow me to put some into one of his eyes. Without any urging on my part, and with a praiseworthy devotion to science, he allowed me.

June 27th.—Three drops of the above-mentioned solution were instilled into his left eye. He complained that they stung a little. Immediately afterward there was slight lachrymation.

Five minutes : Anæsthesia of cornea and conjunctiva complete ; reaction of pupil to light, normal ; no dilatation ; palpebral fissure increased slightly. The doctor complains that there is a "stiff" sensation in the lids.

Eight minutes : Punctum proximum, five inches. States that the lids feel less stiff, but says that the eyeball feels fuller than before.

Ten minutes : Anæsthesia still complete ; palpebral fissure markedly increased : no appreciable difference between the pupils.

Thirteen minutes : P. P., five inches.

Fifteen minutes : Anæsthesia same ; width of palpebral fissure same ; left pupil slightly larger than the right ; reaction to light, direct, accommodative, and consensual, normal ; pupil seems to be wider from above, and outward, downward, and inward ; conjunctiva seems slightly paler.

Eighteen minutes : P. P., five inches.

Twenty minutes : Anæsthesia of cornea and conjunctiva *not* complete ; touching with a strabismus hook gives slight pricking sensation. Dilatation increased ; reaction to light direct, accommodative, and consensual. Does not complain of any blurring of the vision.

Twenty-three minutes : P. P., six inches.

Twenty-five minutes : Anæsthesia and width of fissure same as last recorded ; dilatation of pupil almost *ad maximum*.

Twenty-eight minutes : P. P., seven inches.

Thirty minutes : Anæsthesia abolished ; left pupil dilated *ad maximum* and uniform ; *neither* direct, consensual, *nor* accommodative reaction can be seen. *Right* pupil contracted to pin-head size, and somewhat irregular ; no difference between the tension of the two eyes can be detected. Although the right pupil is contracted it reacts to light, directly, in accommodation and consensually. No systemic effect. Pulse, 80.

Thirty-three minutes : P. P., seven and one-half inches.

Sixty minutes : Palpebral fissure less than at the last recording ; dilatation of pupil still *ad maximum* and uniform ; reaction of pupil to light, direct, accommodative, and consensual, faint. P. P., nine inches.

In the afternoon of the same day the doctor said he was not able to read at all with the left eye ; right eye unaffected.

June 28th, 4 P.M.—P. P., twelve inches ; dilatation about medium ; palpebral fissure normal ; the three reactions of the pupil to the light, faint.

June 29th.—P. P., eight inches ; pupil slightly dilated ; reaction to light, marked.

On the 30th the pupil was normal, with P. P. at five inches.

At no time was there any unpleasant symptom, so that the doctor had no occasion to regret his immolation to science.

In the days following the above experiments a number of foreign bodies were removed from the corneæ of patients, invariably without pain. Usually two drops sufficed, but in one case, in which the cornea was considerably inflamed, four drops were necessary to cause complete anæsthesia. Whenever the conjunctiva was deeply inflamed, it always retained a certain amount of sensibility, which seemed to be in direct proportion to the dignity of the inflammation. Under no condition did the cornea fail to become perfectly anæsthetized to the spud. When the insensibility was wearing off we invariably noticed that the conjunctiva became sensitive before the cornea.

In several cases where more than several drops were instilled the dilatation was alarmingly great ; in fact, the merest rim

of iris being visible. As far as we know, however, the pupils returned in time to their normal sizes.

A number of cases of conjunctivitis simplex were treated with it also. We invariably noticed some constriction of the vessels, but which by no means approached that caused by cocaine. It was the uniform verdict of the patients that their eyes felt better and clearer after its use.

In two cases of iritis where the iris was tightly bound down, great effect was observed from only two drops. In one case of trachomatous pannus, the pupil was not dilated *ad max.* at the end of an hour, although six or seven drops had been instilled.

We observed irregular dilatation of the pupil in three cases besides Dr. Allis'; one patient, however, had, in the eye treated, partial atrophy of the optic nerve; in this same case we also observed irregular contraction of the pupil in the untouched eye, but not to the pin-head size.

With a view to ascertaining the effect of the drug on the mucous membrane of the nose, my friend, Dr. L. P. Walker, of this city, painted the solution on the mucous membrane covering my right turbinated bone. In ten minutes I was not able to feel the pressure of the probe at all, and had I had my eyes shut, would not have known that he had touched it. Contact of the probe with parts where the solution had not been placed, settled beyond a cavil the correctness of my observation. The doctor told me he observed a slight blanching, but no contraction to speak of. This might be explained by the fact that only very little of the solution was used.

Dr. Walker also placed into my right ear, at my suggestion, four or five drops of the solution. At the end of twenty minutes a probe was allowed to rest upon the drum; at first there was only tactile sensation, but after a few seconds there was slight pain.

Having waited ten minutes more, he touched the drum in various places. I cannot say that there was pain then, but certainly there was the very unpleasant sensation which one has from striking the drum gently with some blunt instrument. At my request he then touched the drum of my other ear, in which there had been nothing put. The sensation was almost the same, but I think I can conscientiously say that the drum on which the solution had rested was slightly less sensitive than

the other. No unpleasant symptom was caused other than a slight deafness from the presence of the fluid on the drum. This passed away as soon as the fluid was allowed to trickle out.

With reference to its anæsthetic effect on the skin, Dr. Seward had informed me that he removed, under its influence, a wart from a young lady's face by cauterization with the pernitrate of mercury, without any pain. Having saturated a thin piece of absorbent cotton with the two per cent. solution of the drug, I placed it on the anterior aspect of my left forearm. At the end of twenty minutes the skin could be pricked with a scalpel without any sensation. In ten minutes more I made an incision of one half inch in length in the area which had been covered by the drug. In passing through the cuticle there was the faintest sensation; having passed this, there was absolutely no sensation. I placed several drops of the solution in the wound and continued to dissect, I think, about as far down as the thick fascia, without any sensation, save the grating of the knife against the connective tissue.

In further proof of the anæsthetic effect on the skin, I submit the following:

An Irishman of fifty years presented himself at the Northwestern Dispensary with *otitis media catarrh. acuta*. I observed a sebaceous tumor on his forehead, between the hair and the left eye. I suggested to him to have it removed, telling him that I thought it could be taken away without any pain. He consented. A thin piece of cotton was saturated with the solution and tucked over the tumor and its vicinity; in twenty minutes the skin could be pricked without any pain. In ten minutes more I made a long horizontal incision across the tumor, dissected the skin from around the sac down to the bone, and removed it *in toto*. The man sat perfectly still and said nothing during the whole operation, save at one point, where I made a deep sweep into the connective tissue; he merely observed it scratched a little. Several drops of the solution were immediately instilled in the neighborhood, and in a few seconds I continued to the end without another word from him. When asked if it hurt, he said he had often been hurt worse by the scratch of a pin. Passing of suture caused no pain, and the wound, dressed antiseptically, healed by first intention. The patient seemed very much surprised when I showed

him the tumor, and expressed himself as dumfounded.

I have made no experiments on the physiological effect of the drug when introduced into the general system. It should be borne in mind that only a limited quantity of a two per cent. solution was used in the above experiments.

From analogy it would be reasonable to expect that the anæsthetic effect would be increased by stronger solutions. In its effect upon the eye it seems to stand midway between atropine and cocaine. Its anæsthetic effect lasts about as long as that of cocaine; its mydriatic effect is greater than that of atropine, while its paralyzing effect upon the muscle of accommodation is perhaps as great as that of atropine, reaching its maximum effect in about six or seven hours, and disappearing rapidly thereafter. It would seem to be indicated wherever cocaine is, so far as its antiseptic properties are concerned, and where atropine is, so far as its mydriatic properties are concerned. In fact, for irides rendered sluggish by inflammation it seems to be superior to atropine, though the duration of its effects, as we have seen, is by no means as great.

In Dr. Allis' case I was not able to detect any difference in tension, even when the pupil was dilated *ad maximum*.

After examining a number of eyes at the same time, I may confidently say that in seven instances I have observed a *diminution* in tension when the pupil was dilated *ad maximum*, though I have not been able to detect it in all cases. If this property can be settled beyond a doubt, it will truly possess a phenomenal characteristic, of peculiar interest with reference to glaucoma. The contraction of the opposite pupil, though it has not been observed in all cases, was marked in several, particularly in Dr. Allis'.

From the foregoing observations its therapeutic value in eye diseases cannot be inconsiderable.

There is no reason to assume that it will not cause anæsthesia of all mucous surfaces as it has been shown to do in the eye and nose. In view of the results obtained by myself, I feel safe in predicting for it a wide field of usefulness in all departments of surgery where local anæsthesia is desired, and it only remains for further experiment to develop all its possibilities.

It may fairly be reckoned as a rival of cocaine.

Dr. Seward informs me that the winter leaves yield seven and a half grains of the alkaloid to every ten pounds, while the summer ones yield only five grains to every ten pounds. The supply of the alkaloid is very small at present and the price very high. An ounce of a two per cent. solution costs \$6, which would give sixty cents as the cost per grain. These figures remind one strongly of the market value of cocaine soon after its introduction.—*N. Y. Med. Record*, July 30, 1887.

[Knapp, from later experiments, using Claiborne's solution, concludes that the new local anæsthetic is very similar to cocaine, chiefly differing from it by its more powerful and lasting mydriatic property. This difference determines its range of applicability.

1. Everywhere, when dilatation of the pupil is desirable—*i.e.*, in all conditions that have a tendency to congestion and inflammation of the iris—stenocarpine, either alone or in combination with atropine, is beneficial, and preferable to cocaine.

2. Though its mydriatic effect be less persistent than that of sulphate of atropine, stenocarpine may be used with more advantage when in iritis there is increase of eyeball-tension, a tendency to glaucoma, and when there is great pain. Further observations have to show whether or not stenocarpine, as other mydriatics, leads to granulations of the conjunctiva. If it do not, it will be very valuable in cases of chronic iritis.

3. Stenocarpine is inferior to cocaine when we want anæsthesia without mydriasis, as is the case in the majority of operations—removal of foreign bodies, paracentesis and incision of the cornea, iridectomy, extraction of the cataract,—more especially when in this operation the iris is spared,—operations on the conjunctiva, the lachrymal apparatus, and the eyelids. For an ophthalmoscopic examination, homatropine will be preferable.

4. If we want to be certain of a complete paralysis of accommodation, for which stenocarpine is as reliable as sulphate of atropia, stenocarpine deserves preference, because its action lasts only half as long.

5. Applied externally to an unbroken cutis, it produces no anæsthesia. Observations to the contrary mentioned by Goodman and Claiborne must be owing to peculiar conditions which further experience has to determine.

6. Small doses (four drops) rapidly absorbed may produce transient general symptoms—pallor of the skin, cold perspiration, dizziness, stupor, fainting, nausea, and weakness. The same symptoms are produced by cocaine.

7. Larger doses cause the most alarming general symptoms—violent tetanoid convulsions, opisthotonus, dilatation of the pupils, excessive acceleration of pulse and respiration, and prostration.

8. Introduced into the veins, stenocarpine is the strongest poison, causing death almost instantly by arrest of respiration and pulsation.

9. It is certainly dangerous to inject even small quantities into vascular tissues, such as the orbit, for instance; it appears even unsafe to inject it under the skin in quantities exceeding ten minims of a two per cent. solution—*i.e.*, about 0.01 ($\frac{1}{10}$ grain). We should also be on our guard if we apply it to an open wound during the progress of an operation.

10. The symptoms of poisoning, as has been seen from the above description, are like those from strychnine. The affinity of the two substances should be further investigated. The chemical tests for the detection of strychnine applied to stenocarpine have proved negative. The reflex excitability from stenocarpine is less than from strychnine; also its toxic effect is considerably less. I instilled into the eyes of a rabbit four drops, and into one eye of another two drops of a two per cent. solution of nitrate of strychnine. Both animals died from tetanoid convulsions in ten minutes. Ten and fifteen minims of a two per cent. solution of cocaine injected into the orbits of rabbits had no general effect.]

—*N. Y. Med. Record*, Aug. 13, 1887.

On Recent Renal Surgery.—The medical journals for the past few months have contained many reports of various operations on the kidneys and nephrotomy, the extirpation of the kidney, nephrotomy, the incision of the kidney, and nephrolithotomy; the removal of calculi from the kidney are thus shown to be fully established operations.

Many of the reporters call attention to

the difficulty in some cases of making a positive diagnosis of the lesion, of determining whether the symptoms are due to a calculus, abscess, or malposition of the kidney; and Mr. Thorton,¹ in one instance, having every reason to do so, made a diagnosis of calculi in the left kidney, and opened the abdomen, expecting to remove calculi from that organ, but on palpation, none were detected. In the right kidney, however, calculi were felt, and five removed.

Then, too, it is important to know, especially if nephrotomy is contemplated, the condition of the supposed unaffected kidney. In women the ureters can, without much difficulty, be catheterized, and the urine of each kidney separately collected and examined. In men this cannot, as yet, be satisfactorily done.

Of tumors of the kidney, Tait² says the diagnosis is not at all difficult.

In the first place, its situation makes it distinctly different from tumors of the pancreas, with which it is most easily confused, and its peculiar mobility is a further sign upon which great reliance may be placed for the diagnosis. All enlarged kidneys are freely movable in the direction horizontal to the axis of the body, but they are not easily movable, if at all so, in the vertical axis of the body.

Tumors of the pancreas are movable with great difficulty in any direction.

Tumors of the gall-bladder are very often very freely movable, but neither tumors of the gall-bladder or pancreas can be felt from behind, whereas a tumor of the kidney can be embraced between the fingers if one hand is placed on the outside of the quadratus muscle and the other over the most prominent part of the tumor, and when the tumor can be felt between these two points it is pretty certainly renal.

The characteristic symptoms of renal calculus are lumbar pain, usually constant and increased by exercise, hæmaturia, renal colic, and sensitiveness to pressure over the kidney. Of these, the first is considered the most constant, and ten³ recently reported cases bear this out.

In eight of these cases marked lumbar pain was pretty constantly present. In

¹ *Brit. Med. Jour.*, Feb. 19, 1887.

² *The Southern Clinic*, Feb., 1887.

³ *Page, Edinburgh Med. Jour.*, March, 1887.

Gardner, *Australian Med. Jour.*, March 15, 1887.

Cheesman, *Med. Press West. N. Y.*, Feb., 1887.

Pickering, *Brit. Med. Jour.*, Nov. 6, 1886. ●

Gross, *Med. News*, Dec. 18, 1886.

Agnew, *Med. News*, June 18, 1887.

Shepherd, *Med. News*, April 23, 1887.

Franks, *Lancet*, Dec. 25, 1886.

May, *Birmingham Med. Jour.*, Jan., 1887.

Lange, *N. Y. Med. Jour.*, Feb. 26, 1887.

two the pain was moderate, except after exercise, when it was severe.

In one case only was there constant hæmaturia. Three had bloody urine at intervals. In six cases there was no blood in the urine at the time of operating. Of these six, one had had an attack of hæmaturia six years previously, one two years previously, and one "some time past."

Four had had attacks of renal colic, two had had none, four not stated.

Pressure caused pain in six cases. In one it was not painful. Three not stated.

Tait¹ reports a case in which the symptoms of stone were well marked—severe lumbar pain for five years, hæmaturia, pain on pressure,—and which at the operation proved to be a case of renal abscess.

One other case he reports, in which he made the diagnosis of renal calculus, and which was one of pyonephrosis.

There is some dispute as to the most favorable incision to be made for nephrotomy, many preferring the oblique lumbar incision for this as well as for nephrotomy. Gross considers this the safer operation, as does Tait.

For nephrotomy or nephro-lithotomy nearly all writers recommend a lumbar incision, nearly parallel with the twelfth rib, and about one and one half inches below it. König² has used, and advises, an incision extending from just below the twelfth rib, along the outer margin of the erector spinæ muscle, nearly to the crest of the ilium, thence extending in a curved direction to the outer border of the rectus muscle, just above the umbilicus. The latissimus dorsi, oblique and transverse abdominal muscles are then cut through. To prevent ventral hernia, it is important that these muscles be sutured again, hence König advises that a suture be passed through each layer as soon as divided, so that it may later be promptly identified and firmly sutured.

The kidney is then exposed behind the peritoneum. If for diagnostic or operative purposes it is desired to approach the kidney from the peritoneal cavity, the peritoneum is incised along the anterior curved incision. This incision should be sutured before the pus, if present, is evacuated.

Thornton³ declares that the combined abdominal and lumbar incision is the very

best procedure. Through the abdominal incision the hand is introduced, and each kidney is palpated to confirm the diagnosis as to the morbid condition of the one and the normal condition of the other. Should a calculus be felt, it is held with the left hand, while the right hand is used to make an incision in the lumbar region down to the stones.

Henry Morris, in the discussion upon this method of operating, said that he thought one could palpate the kidney with more ease and precision through the lumbar incision than through the abdominal incision.

Marsh⁴ reports a case of suspected calculus in which he made a vertical lumbar incision, but failed to find the kidney. Subsequently the abdomen was opened in the middle line and the kidney easily found.

It was movable and atrophied, but no calculi could be felt. The kidney was then removed by the ordinary lumbar incision, and on section several small calculi were found in one of the calices.

Tait employs the lumbar incision, unless the kidney is sufficiently enlarged to be called a tumor, in which case he makes an abdominal incision over the most prominent part and in the most prominent axis of the tumor.

In cases of suspected renal calculus, after the kidney is exposed, if the finger fails to detect a stone a needle may be passed into the kidney to sound for a stone in the pelvis. Several punctures should be made, if necessary, as there is little hemorrhage, and this is readily controlled by slight pressures.

The following is a good account of the ordinary operation of nephro-lithotomy. It was performed by Gross⁵ on a man aged thirty-five years.

"The patient having been placed under the influence of ether, and resting on his right side with a pillow under the abdomen and loin, an incision, four inches and a half long, and beginning at the edge of the erector spinæ muscle, was made parallel with the last rib, and three quarters of an inch below it, and carried through the successive layers of muscles and aponeuroses, until the perirenal fatty tissue was reached. During this stage of the procedure two arteries in the latissimus dorsi and

¹ *Southern Clinic*, Feb., 1887.

² *London Med. Record*, Dec., 1886.

³ *Op. cit.*

⁴ *Med. Press*, Feb. 2, 1887.

⁵ *Op. cit.*

internal oblique muscles were secured with catgut ligatures. The circumrenal fat having next been torn through with forceps, the index finger, passed over the posterior surface of the kidney, came in contact with a hard substance at the site of the central infundibulum of the organ, which, on the insertion of a long needle proved to be a stone. The overlying renal tissue was then scratched through with the finger-nail, and extraction attempted with a small lithotomy forceps. This failing, the anterior wall of the belly having been pressed backward by an assistant, the object was accomplished by the combined use of the finger and scoop, and the slight hemorrhage was arrested by pressure with a sponge wrung out of hot water. A drainage tube, with a lumen of nearly five-sixteenths of an inch in diameter, having been inserted close up to the opening in the kidney, the edges of the lumbar aponeurosis were approximated with buried catgut sutures, the divided muscles were united with two tiers of the same material, the deep fascia was secured with a single row, and the skin and superficial fascia were brought together with the continued silk suture. The objects in thus uniting the divided tissues were to facilitate rapid healing and guard against the occurrence of hernia of the descending colon. The outer dressings consisted of gauze and jute, secured in position by a broad roller. The strictest antiseptic precautions were observed throughout, the materials used for the sutures, ligatures, and dressings having been prepared with the usual solution of corrosive sublimate, and the instruments having been thoroughly scrubbed and soaked in a three per cent. solution of carbolic acid."

The patient made a good recovery.

Shepherd,¹ of Montreal, removed through a lumbar incision a calculus weighing four ounces and seven drachms, and measuring nine inches in circumference—the largest calculus ever removed through a lumbar incision. The patient lived three and one half months after the operation.

Weir² performed abdominal nephrectomy for adenoma of the kidney, and successfully removed the growth which weighed twenty-one ounces. The first diagnosis made was renal calculus, and a lumbar incision was made exposing the kidney. A needle failed to detect a calculus, and, as

the kidney was too much enlarged to admit of removal through a lumbar incision, nothing more was then done. Later an incision was made on the outer side of the left rectus muscle about five inches long, and the abdomen opened. The intestines were pushed aside with large flat sponges, and the peritoneum covering the tumor incised on the inner side of the descending colon, and the kidney reached. A few minutes' dissection with the finger allowed the root of the kidney to be exposed, when this was easily surrounded with a heavy silk ligature by means of Mott's aneurism needle, and the vessels and ureter tied off *en masse*; a heavy clamp was then applied between the ligature and the kidney, and the latter cut away, and after some tedious tearing of cicatricial adhesions on its posterior surface resulting from the first incision, it was removed. The clamp was then found to have slipped, and allowed a vein which had entered the kidney above the ligature to bleed freely. This showed most happily the control the anterior incision gives in this respect. The bleeding vessel was distinctly seen, and in a moment controlled by a fresh clamp and ligated. Very little blood was lost, though, during the stripping process, which was conducted between the capsule and its fibro-adipose envelope for a short time, quite a smart oozing of venous blood took place. A long pair of dressing forceps was then forced from in front through the old cicatrized track to the loin, and a large-sized rubber drain carried in from here to the cavity left by the extracted kidney. The divided and torn edges of the peritoneum, which had covered the kidney, were united by numerous Lembert sutures, thus inverting their edges, and after a final toilette of the peritoneal cavity, which was only so in name, as nothing had entered it, it having been so thoroughly protected by the sponges, the parietal peritoneum was sewn together with catgut, and the abdominal wall closed by silver-wire sutures supplemented by additional catgut ones. As some oozing of blood persisted from the drainage tube, several yards of sublimate and iodoform bandage were stuffed into the posterior cavity, and over all peat bags and other antiseptic dressings applied.

The patient recovered. This case is the fourth one on record of adenoma of the kidney.

¹ *Med. News*, April 23, 1887.

² *Med. News*, March 12, 1887.

Lucas' reports the case of a married woman, aged thirty-seven, who had suffered some years from painful movable right kidney. He exposed the kidney by the lumbar incisions, and secured it to the lumbar aponeurosis by sutures. The pain was at once relieved and the patient made a good recovery. Other similar cases are reported.

GEORGE B. PHELPS.

On Intubation of the Larynx.—This procedure can hardly be said as yet to have found its place. On the one hand, it is claimed that the results with tracheotomy, in diphtheria and croup, are equally good, and that the difficulties and dangers of intubation are not fully appreciated; while, on the other hand, the more enthusiastic advocates of intubation regard it as a "god-send to humanity." On the whole the question is being debated in a spirit of judicial fairness, and there is reason to hope that the experiments now being made in the direction of overcoming the obstacles and testing the merits of the operation may lead to its establishment as a recognized surgical measure in suitable cases. At the recent meeting of the American Laryngological Association, Dr. Sajous, of Philadelphia, reviewed the objections to the operation and the way in which they may be met, and presented a new set of instruments. He says:

"Taking the principal objections to intubation, and arranging them according to the degree of danger attending them, we have:

1. Obstruction to the tube by fragments of membrane.

"2. Crowding down of loose membrane during introduction of the tube.

"3. Passage of food through the tube into the trachea, and consequent inability to feed sufficiently through the mouth.

"4. Momentary arrest of respiration during introduction, and shock resulting therefrom.

"5. Liability of the tube to be coughed out, and slipping of the tube into the trachea."

The first objection he would overcome by using tubes of larger diameter, approaching as nearly as possible the dimensions and conformation of the normal larynx. The second difficulty may be obviated by making the tube shorter. With regard to the third difficulty the author, after referring to Waxham and Ingals, who

prohibit the ingestion of fluids while the tube is in position, and to O'Dyer, who has suggested that the mobility of the epiglottis may be impaired by inflammatory thickening, explains the trouble by the fact that the ascent of the larynx, a movement performed in every act of deglutition, must necessarily be impeded by the *weight* of the tube. The tube should, therefore, be made lighter. The fourth objection is due to the presence of the obturator in the O'Dwyer tube. It is advisable to abbreviate the attempts at introduction as much as possible, and to dispense with a tube requiring an obturator. The fifth objection may be overcome by conforming the tube to the shape of the larynx, so that it may offer as little resistance as possible to the expiratory air current. The sixth difficulty is likely to arise from narrowness of the head of the tube and its excessive weight, as well as from the selection of too small a tube. The instruments which Sajous has devised with the idea of obviating these difficulties comprise a bivalve "throat-piece," instead of a tube, and a pair of forceps for applying and withdrawing the former. The "throat-piece" is of thin metal and is modelled on a cast of the interior of the larynx, so modified as to avoid contact at the anterior and posterior commissures and to prevent pressure at any point. It fits into the ventricles of the larynx in such a way that the vocal bands prevent the descent and the ventricular bands the ascent of the tube. The advantages claimed for this form of instrument are as follows:

1st. We have almost the same breathing space as in the normal larynx, thus preventing as much as possible obstruction by detached membrane.

2d. The comparative shortness of the instrument and the early separation of the lower portions of the valves reduce greatly the danger of crowding down loose pseudo-membrane.

3d. The light weight of the instrument and the shape of the head avoid interference with the act of deglutition.

4th. Separation of the valves a short distance above their tips, when closed, enables the patient to breathe freely while the instrument is being introduced.

5th. The fact that the force of the air-current is exerted in the centre of the instrument and has sufficient space to pass freely, renders ejection during cough almost impossible.

6th. The breadth of the head, the facility with which it can be grasped by the forceps, combined with the lightness of the instrument, make it impossible to force it into the trachea without fracturing the thyroid cartilage.

The author has also designed a spiral tubular forceps for removing detached membrane from the trachea, which he has used with satisfaction. The "throat-piece" has not yet been tried upon the living subject. A similar bivalve instrument was experimented with by O'Dwyer quite early in his investigations, but was abandoned, for the reason that the mucous membrane of the interarytenoid space and adjoining parts pressed forward between the valves and caused dyspnoea. Sajous thinks this accident resulted from joining the valves together at too high a point, and, accordingly, in his instrument the hinge is placed so low that from nearly half an inch below the true cords an almost closed tube is formed.—*N. Y. Med. Four.*, July 23, 1887.

In connection with the third obstacle, as enumerated by Sajous, the concluding remarks in a recent article by O'Dwyer are of interest, (*Med. Record*, N. Y., June 18, 1887). In two cases light hard rubber tubes were substituted for the heavy metallic tubes. One of the patients expressed a decided preference for the heavy tube, which, she said, sank deeper in the larynx and enabled her to swallow more easily than did the light-rubber tube. But although one weighed one ounce and three quarters and the other only one hundred grains, she could not appreciate any difference in the weight as it was in position in the larynx. The other patient, while she could not swallow as well with it, was equally strong in her preference for the lighter tube, saying that it gave her less pain and irritation, and enabled her to expectorate more easily. In the same paper Dr. O'Dwyer expresses his disbelief in "food-pneumonia," for three reasons: (1) fluid entering the tube is promptly expelled by coughing, and does not reach the bronchi; (2) pneumonia is rarely, if ever, developed in cases in which the croupous process does not enter the bronchi; (3) intubation for chronic stenosis in the adult is never followed by pulmonary inflammation. This after-risk of intubation would seem to be of the most vital importance in the minds of some operators, as indicated by a discussion upon a paper read by Waxham at

the last meeting of the Am. Med. Ass'n (*Four. Am. Med. Ass'n*, July 30, 1887). This observer, whose experience has been exceptionally large, shows a record of seventy-two cases of three years or under, with recoveries amounting to 22 per cent. His percentage of recoveries in cases above the age of three (64 cases, 21 recoveries, 32 per cent.) compares favorably with tracheotomy. Drs. A. B. Strong and W. P. Hatfield were pronounced in their opposition to intubation, the former announcing his intention not to operate again, until some modification of O'Dwyer's tube enables the child to swallow nourishment. He also called attention to a very extraordinary accident, which he had several times witnessed, namely the making of a false passage in introducing the tube, the end of the tube being pushed through the mucous membrane just above the hyoid bone. It is not unnatural to hope that the operator capable of performing this dexterous feat may direct his talents in some other channel, and save intubation from undeserved obloquy. Dr. Dillon Brown has compiled the statistics of intubation, of which the following is a summary:

Total number of operators, 65.

Total number of cases, 806, with 221 recoveries, = 27.4 per cent. Male, 225; female, 198.

Average age of fatal cases, 3 years 2 months.

Average age of cases which recovered, 4 years 1½ month.

Duration of laryngeal symptoms before intubation in cases of recovery, 2 days 9 hours; in cases of death, 1 day 19 hours.

Urine contained albumen in 117 cases, and no albumen in 31 cases.

In fatal cases, average length of life after intubation, 2 days 8 hours.

In cases of recovery, average time of tube in larynx, 5 days 3½ hours.

Cause of death in 339 cases:

Diphtheritic bronchitis, ...	139
Pneumonia	55
Sepsis	37
Exhaustion	33
Nephritic complications	25
Heart failure	20
Pulmonary oedema	9
Bronchitis	8
Asphyxia, from clogging of tube, ...	2
" pushing down membrane	2
Asphyxia, from swelling over head of tube	1
Asphyxia, from neglect to notify operator after coughing out tube	4
Tuberculosis	2
Congestion of lungs	1
Scarlatina	1

The tabulated report, from which these

figures are taken, shows quite a large number of recoveries in children under three years of age, who in all probability could have been saved by no other resource. (*N. Y. Med. Four.*, July 23, 1887.)

Among recent contributions to this subject is a paper by Stoerk, in *Wien. med. Presse*, Nov. 12, 1887. This operator has found the manipulations of intubation free from difficulty. He thinks it necessary, however, to suggest a new style of applicator, in which the forceps and obturator are combined. The latter is placed between the blades of the former, and terminates in a ball-shaped extremity, which is perforated. (*Four. of Laryngol. and Rhinol.*, May and June, 1887.)

CHARLES H. KNIGHT.

Bull (C. S.) on Passive Motion in the Treatment of Paralysis of the Ocular Muscles.—This department of ocular treatment is not satisfactory even at the best. Many syphilitic cases improve partially only; others not at all. The longer the paralysis has existed the more unpromising is the outlook for recovery. Rheumatic cases of paralysis of the ocular muscles are among the most obstinate. But it is this class of cases that the treatment suggested first by Michel in 1877 proves most useful. It is novel in conception, and offers certain advantages. It is based on the principle of passive motion; is very simple in application. The paralyzed muscle is to be seized at its line of sclerotic insertion with a pair of common fixation forceps, and eyeball is then rotated to and fro in the plane of that muscle's action; up to and even beyond the limit of extreme contraction, and on the other as far towards its complete relaxation. This exercise to be continued for about two minutes. Michel says the effect is greatest immediately after these manipulations, and then gradually diminishes. He also states that the pain produced was trifling, the conjunctival irritation soon subsiding under cold applications. He recommended exercising the muscle daily, and noted the fact of considerable resistance offered by the muscle at first to the manipulation. The advantages claimed by Michel were: 1st, elimination of the action of the antagonizing muscle; 2d, the brief duration of the treatment. The writer, after outlining twenty-one cases in which he has tried this method, sums his results with the following:

The paralysis was entirely cured in eight

cases, partially relieved in six cases, while in seven the treatment proved valueless. Though not brilliant the results are favorable enough to warrant further efforts.

Perhaps passive motion in connection with the careful application of the galvanic current may give better results than have heretofore been attained with long-standing paralysis of the ocular muscles. Michel reports one case, and that a recovery in five weeks. Spalding reports four cases, of which two recovered in three weeks, and the other two were failures. Alt reports five cases, of which three recovered and two were failures. The pain caused by the manipulation when no anæsthetic was used was in most cases very severe, and is not wholly relieved by cocaine. The conjunctival irritation, though considerable, was usually transient. In several cases blood was extravasated beneath the conjunctiva, but was readily absorbed. An attempt was made to substitute a pair of smooth-pronged forceps, such as are employed for epilation, but they proved useless, slipping constantly when traction was made.—*Med. Record*, Aug. 6, 1887.

ARTHUR T. MUZZY.

THERAPEUTICS.

Sée (G.) on Antipyrine by Subcutaneous Injection as a Substitute for Morphine.—In April (18), 1887, the author, when speaking of the analgesic effect of antipyrine, said that it could be given in gr. vii. doses dissolved in distilled water hypodermically. A slightly painful sense of tension was caused by the injection for a time, followed by a considerable remission of the pain of whatever kind.

Subsequent comparison of its effects with those of morphine shows that it lacks many of the bad effects of the latter, particularly the production of vertigo and vomiting, that it does not produce sleep nor the excitation that morphine often does, while, added to its calming action, it has a curative power which morphine never possesses. He has found this hypodermic use of the drug combined with a simultaneous internal administration of the same of the greatest benefit in acute and chronic rheumatic and gouty affections.

He considers it very useful in neuralgias of the face, zona, lumbago, and migraine. He considers it much to be preferred to

morphine in the relief of hepatic and renal colic, angina, and other painful affections of the heart, and for the relief of the dyspnoea and sense of oppression of asthmatic nervous subjects.—*La France Méd.*, July 23, 1887.

Luton (A.) on the Disinfectant Properties of Cocaine.—When the drug is used for anæsthetic purposes it is noticed that the employment of gr. iv. or more a day causes a marked change in various secretions and excretions. The perspiration, urine, breath, products of suppuration, and even fecal matters lose their foetid smell and become entirely odorless. The author has no doubt that this hitherto unnoticed power of cocaine will enlarge its clinical usefulness by substituting it, in some cases of traumatism, for carbolic acid and sublimate.

It is especially in typhoid fever, in the adynamic stage with intestinal ulcers and foetid diarrhoea that he would try the new disinfectant. It should be doubly beneficial as an antiseptic and as a nervous tonic.—*An. Méd. et Sci. du Nord-Est*, July 15, 1887.

Hare (H. A.) on the Influence of Carbolic Acid on Normal and Abnormal Bodily Temperature.—The author concludes as follows :

1. Carbolic acid possesses considerable power in lowering normal bodily temperature.

2. It possesses more influence over pyretic temperature than does salicylic acid, generally preventing a rise or causing a fall of temperature, but sometimes failing to do so.

3. Carbolic acid probably decreases arterial pressure when lowering temperature.

4. That its mode of decreasing normal bodily temperature is as yet not fully understood, although it would seem probable that it acts on both heat functions.

5. When influencing bodily heat in fever it acts chiefly by decreasing production, although it affects both functions.—*Therap. Gaz.*, Aug., 1887.

Jayasingha (W. A.) on Hygrophila Spinosa.—*Hygrophila spinosa* vel *asteracantha longifolia*—a prickly herbaceous plant, common in the marshy places in the hotter parts of Ceylon, belonging to the natural order *Acanthaceæ*—has been tried as a diuretic in several cases of dropsy, chiefly that of anæmia, with success. It is known as *Ikkirie* in Singalese, and *Neer-*

mullie in Tamil. The entire plant is used in medicine ; the practitioners of native medicine in Ceylon consider it as one of the best medicines in dropsy, and is given in the form of a decoction, and locally it is used as a fomentation in cases of inflammation and rheumatism. The ashes of the burnt plant, according to Dr. J. Shortt, in doses of about half a teaspoonful twice or three times a day, is a form of administration followed by native practitioners of India. Dr. Kirkpatrick states that he frequently employed it in dropsical cases, and it undoubtedly possesses considerable power as a diuretic. Dr. Gibson also bears testimony to its powers as a diuretic. It is also favorably reported by several of the surgeons of India.

The two following formulæ for the administration of the drug are given in the *Indian Pharmacopœia* by Waring, namely :
Decoction—Take of *asteracantha* root one ounce ; water, one pint ; boil to fourteen ounces ; strain ; dose, from one to one ounce and a half daily.
Acetum—Take of *asteracantha* leaves freshly dried two ounces ; distilled vinegar, sixteen ounces ; macerate for three days, press and strain ; dose, four drachms to one ounce.

The mode of administration followed in this hospital is the following, namely, two ounces of the dried plant is infused for half an hour in a pint of boiling water, and strained ; this quantity administered in divided doses to one patient in the twenty-four hours.—*Br. Med. Jour.*, July 16, 1887.

Duroziez (P.). The Reduplicated Pulse as a Guide in the Administration of Digitalis.—The power of digitalis to cause a reduplication of the pulse was first pointed out by the author in 1850. He has since come to look upon the reduplication of digitalis as a warning to stop its administration. If a regular pulse becomes reduplicated, nothing is gained, and the remedy should be discontinued. If an irregular pulse becomes reduplicated, it shows that all the good effect of the drug has been expended.

In this reduplication the pulsations frequently come in pairs, a strong and a feeble one together. The weaker pulsation is often not transmitted to the wrist, so the pulse there may appear regular while the cardiac impulses show the reduplication. This reduplication need not be constant or regular, but it often affects every third, fourth, or fifth beat.

A similar pulse is seen in some cases of bronchial asthma, and can be experimentally produced in animals. The same pulse exists in the veins, although it is reversed. —*La Tribune Méd.*, Aug. 7, 1887.

Young (F. J.) on Imaginary Therapeutics.—On the 10th of January, 1887, I purchased a pound of sugar of milk and a quantity of pure sugar globules, with which I have since been vigorously combating diseases in a way very analogous to the modes of the most advanced homœopaths of the present time.

My first case was one of double pneumonia in a lady 65 years old, one lung becoming involved as the other cleared up. At about the 4th or 5th day, the patient being delirious, with a temperature of 103° and a pulse of 110, counsel was asked for, which resulted in a call for the family physician from New Haven to meet me in the case, whom I found to my surprise to be an enthusiastic homœopathist. He recommended arsenicum 30th and bryonia 30th, so strongly and with such apparent confidence, that I consented to give them a trial, which I immediately put into execution by sending her two packages of my pure milk sugar, to be dissolved in separate glasses of water; the patient to have a spoonful from each alternately every hour. The friends of the patient claim that there was very marked improvement in the case at once. At any rate, convalescence followed as soon, and was as complete, as I have ever seen it in any similar case under the most energetic scientific treatment.

Following this case I have treated entirely on the expectant plan during the two months between January 10 and March 10, 1887, 119 different patients with the most diverse acute complaints, the results of which I present to you in tabulated form, which shows the natural duration of these diseases, under simple, fair nursing, and entirely uninfluenced by medicine. There was of acute pharyngitis 15 cases treated with wet towel applied to the neck—but no medicine or gargle; (15) 4 terminated in recovery in 4 days, 7 in 3 days, 2 in 2 days, 1 in 5 days, and 1 in 1 day.

Acute bronchitis in adults (4 cases), simple poulticing—no medicine.

(4) 2 recovered in 4 days, 1 in 8 days, 1 in 3 days.

Pneumonia in adults (4 cases), poultices and whiskey only.

(4) 1 recovered in 2 weeks, 2 in 10 days, 1 in 1 week.

Eight cases of acute bronchitis in children from 2 to 10 years old, poultices only.

(8) 3 recovered in 7 days, 1 in 9 days, 3 in 3 days, 1 in 4 days.

(1) Quinsy 1 case—aborted in 3 days; no applications; patient never had a quinsy abort before; asks for some of the medicine to keep on hand.

(1) Acute pleurisy severe, 1 case—one dose of morphine; no external applications; cured in 5 days.

(3) Spasmodic croup—3 cases; no applications; no recurrence after second night.

(1) Mastitis 1 case—sugar of milk alone; well in 3 days.

Remittent fever, severe and well marked; 6 cases.

(6) 3 lasted 8 days; 2, 7 days; and 1, 6 days.

(2) Dysentery 2 cases—1 cured in 4 days, 1 in 3 days.

Gastro-enteritis 6 cases.

(6) 2 recovered in 3 days, 1 in 5 days, 1 in 7 days, 2 in 8 days.

(1) Facial erysipelas, patient 65 years old, 1 case—recovery complete in 7 days; no applications.

(1) Uterine hemorrhage at menopause, 1 case, had lasted 2 months; cured in 4 days.

(1) Gonorrhœa, 1 case—cold water injections; well in 11 days.

Pharyngitis and gastritis combined, 6 cases.

(6) 2 lasted 7 days, 4 each 3 days.

(2) Vomiting from teething 2—nothing done; 1 lasted 2 days, 1 one day.

(11) Gastritis in children from 1 to 4 years old, 11 cases—4 recovered in 7 days, 2 in 4 days, 3 in 3 days, 1 in 2 days, and 1 in 1 day.

(4) Gastritis and enteritis acute, and apparently dangerous—4 cases; 1 lasting 7 days, 2 five, and 1 three days (poulticed).

(4) Mumps 4—all did well.

(1) Orchitis in mumps 1 case—lasted 5 days.

(2) Whooping-cough 2 cases—very rapid improvement.

(3) Worm fever 3—lasted 2 days.

(3) Convulsions from teething 3 cases—all recovered in 24 hours.

(4) Measles 4 cases—3 to 8 days.

(7) Capillary bronchitis 7 cases—2 seven days, 3 eight days, 1 four days, 1 nine days; poulticing only and whiskey.

(2) Scarlatina 2 cases—well in 4 days.

(1) Acute laryngitis 1 case—8 days; inhaled steam only.

(1) Hæmaturia in acute nephritis 1 case—5 days.

(2) Pelvic cellulitis, severe, 2 cases—about 10 days.

(10) Winter cholera 10 cases—average duration 3 days; relief immediate.

(2) Acute gastritis in adult 2 cases—1 four days, 1 ten days.

In justice to myself, I wish to say that my observations have not lessened my faith in the rational application of medicine to diseased conditions.

The results of these experiments have proven what, in my mind, before was a confirmed suspicion, that the recoveries of patients under homœopathic treatment were, largely at least, due to faith and nature, and not to medicine.

We have abundant reasons for believing that, treated entirely on the expectant plan, which means the letting of a disease run its inevitable course without medical interference, all of the infectious diseases, and in fact nearly, if not quite all acute diseases, are bound to run their regular course, and in due time terminate spontaneously. We ought, therefore, to confine our exhibition of drugs to the use of those having a specific action, where we have reason to believe in the existence of such; and when, as is generally the case, we have reason to believe that we do not possess such for any given diseased condition, then our entire endeavor should be to see to it that the patient outlives the disease. And this duty can often be accomplished by means classed under the head of nursing, alone, fully as well, if not better, without the administration of drugs as with them.—*New England Med. Monthly*, July 15, 1887.

Brodnax (B. H.) on the Abuse of Quinine.—O. F., aged eight years, healthy and robust for this climate, had an attack of uncomplicated pneumonia. Being an only son the parents, on the fourth day, proposed a consultation. The physician, of twenty years' experience, advised quinine in three-grain doses every hour for four hours, "to prevent the recurrence of the fever," which had commenced to rise at 4 P.M. and declined about midnight. Though not in accordance with my ideas, I gave the medicine as directed, commencing at 1 P.M. Contrary to his prediction the fever commenced before 4 o'clock, rose

rapidly, thermometer at 12 P.M. standing at 103.5°; patient having passed a very restless night, partially delirious, the fever subsiding at 9 o'clock next day. The same course was pursued on the fifth day with similar effects.

Becoming alarmed the mother, on the sixth day, asked me "the cause of the increase of bad symptoms." In reply I proposed that "we let the quinine alone and give only the cough mixture as usual." She watched the case anxiously with me; the rise of the fever was gradual from a little after 4 o'clock until 9, became steady at 101.5°, and subsided about midnight, the boy having passed an easy night, sleeping most of the time. He made a good recovery without any more quinine.

The symptom that misleads is the rise in temperature every day at about the same time, leading the practitioner, in malarial districts, to assign it to that complication, and then quinine, because of its known effect in controlling periodicity, comes in play.

Let me here say that during twenty years' careful observation, in a district where malaria "lives and boards at same place," I have never met a case of fever arising from inflammation of any character that I believed was in any way complicated with malaria, or benefited by quinine. I have seen chills follow after a severe case of sporadic typhoid fever that had run its course and was convalescent; I have seen the same in pneumonia. But I can hardly be led to believe that the remissions of inflammatory fever were caused or aided by malarial complication, where such facts are almost ever before me.

I am tempted to think fashion has a great deal to do in the matter, and of opinion that if a physician will divest himself of his books and with thermometer in hand will sit by his patient, and for forty-eight hours watch the effects of its administration, he will have some very sage doubts as to the reality of a sedative dose of quinine.—*Medical Register*, July 13, 1887.

Bave (J.) on Treatment by Prolonged Immersion in Water, and the Use of the Water-Bed.—As the author says "this treatment is not by any means new, yet it is so seldom adopted as to make the case which I have thus treated worth recording. Prolonged immersion has been extensively used by Hebra in the treatment of certain skin affections, and I

believe it has been frequently adopted by Mr. Jonathan Hutchinson, though I am not cognizant of the nature of the cases which he has thus treated. It has often occurred to me, when I have heard the harrowing cries of patients who were having extensive burns dressed, that they might be more effectually and comfortably treated in an antiseptic warm bath. I have no doubt that many lives might thus be saved, and the exit of fatal cases rendered less painful. I therefore hope that the bath may come into more frequent use with our surgical colleagues."

The case in which he employed it was one of pyæmia, in a girl of 18, with acute periostitis of the left femur, acute arthritis of the left hip and knee joints, and extensive bed-sores.

The lower part of this patient's body was immersed for 17 weeks in water, the ultimate result being recovery; had an anæsthetic when her bed-sores were being dressed. The patient was given a little chloroform, swung in a sheet, and immersed in a boracic bath, at a temperature of about 95° Fahr. The water of the bath was kept as nearly as possible at this temperature, and the patient was deeply immersed, so as to nearly float her body.

The water was occasionally changed, and by means of the sheet she could be raised out of the bath for sanitary purposes, and, when desired, to see how the sores were progressing.

Incorporated in the foregoing article is the history of a similar case similarly treated by C. Puzey.

"A boy, about twelve years of age, was admitted into the Royal Infirmary with disease of the tarsus, for which Syme's amputation was performed.

"Pyæmia resulted in the formation of numerous abscesses in various parts of the body, and also in such a feeble condition of nutrition that bed-sores formed in every part which was subjected to the slightest pressure, and his skin was undermined in every part. I kept him immersed (except his head and neck) for nearly four months, at the end of which time, as all the sinuses and abscess cavities seemed filled up, and nothing but granulating superficial wounds remained, I had him removed from the bath and laid on a water-bed.

"The plan I adopted was to have a light framework of wood, with a raised portion for the head, and over this framework

stout sheeting was nailed. This framework floated in a large ordinary bath, but when the patient was laid on it a slight support was required, and this was obtained from two bands of webbing nailed on each side of the bath. Thus the patient partly floated on the platform, but mostly he was borne up by the water itself; and to prevent his head slipping off the pillow and into the water, a girth, passing over his chest and under his shoulders, was fixed to the head of the bath.

"The water was easily kept up to a regular temperature, and was changed at first every few hours; but after the profuse discharge had ceased less frequently, and towards the termination of the case only once a day."—*Liverpool Med.-Chir. Four.* July, 1887.

Andrews (E.) on the Removal of Necrosed Bone by Irrigations with Weak Hydrochloric Acid.—In almost all cases of necrosis the dead bone can be removed without operation by the simple process of daily irrigation with diluted hydrochloric acid. This is especially important in spinal necrosis and caries; but is also applicable to necrosis in other parts of the body.

So far as my investigations have yet gone, I find no solvent equal to a weak solution of hydrochloric acid. Sulphuric acid seems to limit its own action by precipitating the insoluble calcium sulphate in the Haversian canals, and blocking the further access of the acid. Thin laminæ of bone will lie in a dilution of this acid for days with only a slight degree of decalcification. Chromic acid is also inefficient, and stains the linen on which it happens to drip. Nitric acid decalcifies the bone rapidly, but I have not yet finished the experiments for ascertaining its practical usefulness.

The proper strength of the hydrochloric solution varies with the tolerance of the patient, the object being to keep it just below the painful point. This will usually be found between one fourth and one sixteenth of the strength of the official *acidum hydrochloricum dilutum*, although it can be employed somewhat stronger by the addition of cocaine and morphine. The tolerance seems to be determined largely by the presence or absence of a good coat of granulations upon the living tissues. Directly after an operation, the cut extremities of the nerves are painful on the application of any acid, however weak; but after a few

days, when covered by granulations, they bear comparatively strong solutions without difficulty.

The length of time required will vary with the strength of the solution, and the constancy of the irrigation. The following experiments were made outside the body to get an idea of the rapidity of the action of the acid. Fragments of actual sequestra which had been removed by operation were placed in bottles of acid of various strengths, and the time required for complete decalcification noted.

Experiment.	Strength of Solution.	Dimensions of Sequestra.	Time required for Decalcification.
1	the strength of official dilute hydrochloric acid.	4½ cm. by 1 cm. by 3 mm.	hours. 142
2	do do	3½ cm. by 14 mm. by 4 mm., very hard seq. from tibia.	120
3	do do	4½ cm. by 28 mm. by 20 mm. Very spongy tuberculous trochanter.	24
4	do do	9 cm. by 32 mm. by 5 mm.	117
5	do do	38 mm. by 9 mm. by 4 mm.	120
6	do do	2½ cm., very hard sequestr.	128
7	do do	5½ cm. by 13 mm. by 1 cm.	102
8	do do	5½ cm. long, whole thickness of shaft of femur, diam. 2 cm.	96
9	do do	32 mm. by 13 mm. by 3 mm.	102
10	do do	64 mm. by 38 mm.	54
11	do do	Block of cancellated bone 16 mm. diameter.	78
12	do do	Sundry small splinters.	54

Average time of solution, about 95 hours.

These experiments show that old sequestra, which have lain long in putrid suppurating cavities, are not deprived of their gelatiniferous animal basis. In every instance the decalcified animal matter remained in full form, but, lying enclosed in granulations inside the body, it is rapidly absorbed, exactly like the decalcified bone drainage-tubes when left in position.

The method of effecting the irrigation is important. If one simply pours a little acid into the fistula, as Billroth evidently understood the plan to be, he will accomplish nothing. It is necessary to irrigate the whole sequestrum either frequently or continuously. If possible, one should have two openings, so situated that the fluid may run into one, and thence along the whole length of the sequestrum and out at the other. When necessary, new openings must be made in suitable positions, and left pervious by drainage-tubes. The next step is to fill a half-gallon fountain syringe with the acid solution, and, hanging it by the

bedside, to let it run very slowly through the diseased channel. If a "through and through" irrigation is not possible, we can often obtain the same result by taking a small flexible catheter, especially of the kind having a curve near the tip, and called by the French *sonde coudée*. By a little careful management this can often be carried to the farthest corner of the cavity, and by attaching it to the fountain syringe it will deliver the fluid beyond the sequestrum, and make it flow over it on its return outside the catheter. Whenever the sequestrum can be thoroughly irrigated, its decalcification is a matter of absolute certainty within a moderate number of days. The hydrochloric solution is a perfect antiseptic of itself, and during its use no other is required.

After the solution is completed there remains the gelatiniferous animal matter of the bone, which is identical with the material of decalcified bone drainage-tubes, and like them is rapidly absorbed in antisepticized cavities. I have commenced to investigate the possibility of dissolving it out at once with pepsin, but have not finished that part of the subject.

Billroth raises the objection that the acid will dissolve the living bone as rapidly as the dead, or even more so. So plain a point as this of course cannot fail to rise in every one's mind, but I am sure that great man spoke from mere theory, and not from observation or experience. Whatever one might fear in this respect, I find as a matter of experience that the weak solutions which I have used do not decalcify living bone. Apparently the granulations covering the living osseous tissue protect it from contact with the acid, except in spots denuded by ulceration, and even there the circulation of the alkaline blood in the Haversian canals, and the constant exudation of alkaline serum from all raw living surfaces, bone included, protect it from the action of such weak acid dilutions as I have hitherto used. At any rate, it is a positive fact that the sequestra are dissolved, and the cavity heals, without any perceptible injury to the living bone.—*Four. Am. Med. Ass'n*, Aug. 13, 1887.

Hardy on the Composition and Synthesis of Pilocarpine.—Pilocarpine becomes pilocarpic acid by absorbing a molecule of water. It becomes pilocarpidine by losing methylic alcohol, and pyridino-lactic acid by disengaging trimethy-

lamine. He reproduces it synthetically, first by changing pyridino-lactic acid into pilocarpine, and secondly, by transforming pilocarpidine into pilocarpine. The artificial has the same physiological effect as the natural drug.—*La Tribune Méd.*, Aug. 7, 1887.

Minges (G.) on Pilocarpine as a Galactagogue.—When there is no organic vice of the mammeæ to account for the insufficient secretion of milk, and no constitutional contra-indication exists, experience has taught the writer that it is always worth while to try pilocarpine. This drug, as a rule, shows its galactagogue action in direct proportion to its physiological (diaphoretic and sialogogue) effects; but while the latter are evanescent, the former, once established, continues for weeks or months, an occasional dose being required only in certain cases to spur a flagging secretion, while the long-continued exhibition of the remedy exhausts the gland by over-stimulation. Accordingly, the woman is directed to take $\frac{1}{4}$ gr. of the muriate on retiring, covering up warm in bed, brandy being used as a vehicle to forestall any depression which might be caused by the remedy. If this dose does not cause perspiration and salivation, a somewhat larger one is given on the following evening, and so on until the ordinary physiological effects are produced, by which time the efficacy or usefulness of the drug will have been demonstrated.

Of the eleven cases of insufficient secretion of milk treated by the writer by the above method without any change of diet or general mode of living, want of space allows the description only of the five in which more or less success was obtained.

CASE II.—Mrs. J.—First child having suffered much on account of absence of mother's milk and galactosis, a week after second confinement having gradually become almost nil, although abundant at first, $\frac{1}{4}$ gr. pilocarp. muri. was given night and morning for three or four days, with the effect of causing an abundant flow. Child was nursed for nine months, and had very little gastric disturbance. During this time the supply several times diminished, but was always restored to sufficiency by $\frac{1}{4}$ gr. doses of pilocarpine. With third child, abundant spontaneous secretion, which diminished somewhat in three or four months to be promptly increased again by pilocarpine; but as the quality

never had been good, child had to be weaned a few weeks later.

CASE III.—Mrs. L.—II Para. First child having died of entero-colitis from want of mother's milk, and hardly any having appeared in more than a week after present confinement, pilocarpine muriate was given mother every evening in gradually increasing doses, until $\frac{3}{4}$ grain; caused copious perspiration, salivation, and galactosis, the latter at the present writing still being sufficient to nourish the strong, healthy boy, now 14 months old, although no galactagogue has been used since.

CASE VII.—Mrs. A.—IV Para. First two children raised on bottle. Third child nursed for two or three weeks, at end of which time mammary abscesses arrested secretion, which could not be re-established with pilocarpine after recovery. Infant only saved from impending death by obtaining a wet-nurse for the summer. Two weeks after last confinement amount of mother's milk is insufficient. Two $\frac{1}{4}$ -grain doses of pilocarpine muriate caused an adequate secretion, and no diminution has as yet occurred after three weeks.

The following I regard as a test-case, as a month had elapsed before resorting to treatment, by which time any possible spontaneous galactapoësis should certainly have been established:

CASE VIII.—Mrs. W.—I Para. Child one month old, emaciated to last degree from entero-colitis, mother having had hardly any milk since its birth. While baby was improving on peptonized milk, the mother's mammary secretion was gradually increased by taking every other night one of Wyeth & Bros.' $\frac{1}{4}$ -gr. tablets of pilocarpine muriate, and after third or fourth dose the infant could be fed almost exclusively on its natural pabulum, and soon became as large and strong as others of its age.

The last case will show that pilocarpine can do even in debilitated subjects.

CASE X.—Mrs. M.—V Para. Delicate woman, sick during whole pregnancy, forceps delivery, some post-partum hemorrhage, at end of five days temperature 100° F., little appetite, hardly any milk, child not thriving. To satisfy mother's earnest wish to save the baby, so that it could be christened, I aimed to increase her milk supply. One $\frac{1}{4}$ gr. tablet of pilocarpine muriate caused feeling of great prostration, heat, ringing in ears, salivation, very little perspiration, but an over-abundance of

milk. In two days secretion again diminished, but it was not deemed prudent to repeat the experiment in patient's debilitated condition.—*West. Med. Reporter*, Aug., 1887.

Goelet (A. H.) on Salol and Ice-Water Enemata in the Treatment of Diarrhœa, Dysentery, and Intestinal Inflammation.—Case after case could be cited in substantiation of the value of salol, but it is sufficient to say that it is the only purely satisfactory remedy I have ever used in these cases. I must devote some space to the important matter of dosage in children.

While the adult dose is ten grains, the dose is much larger in proportion for children, and varies very considerably with the age. For a child six months old or under, the dose is half a grain every two hours. From seven to ten months old the dose may be from one half to three quarters to one grain, according to the severity of the symptoms and the strength of the child. A child one year old may be given from a grain to a grain and a half, according to the severity of the symptoms. A child fifteen to eighteen months old may take a grain and a half to two grains. At the age of two years the dose would be two grains. For three years of age the dose would still be two grains to two grains and a half. Children of four years would require only two and a half to three grains, and those of five to six years would require only three or three and a half grains. And from this age to ten it is seldom necessary to give more than five grains. It is always given to commence with every two hours, and as the symptoms are relieved the interval is lengthened to three or four hours. I sometimes give it three or four times a day for twenty-four or forty-eight hours after the subsidence of the trouble.

Diarrhœa and dysentery of children in summer is more promptly relieved by salol than any thing else. Let me here outline a general course of treatment for these cases. To begin with, stop all food for twenty-four hours. If the little patient is thirsty, use a decoction of salep cold. This is made as follows: A saltspoonful of powdered salep is rubbed into a paste in a cup with a tablespoonful of cold water and a pint of boiling water added slowly, stirring it all the while. This is set on the ice, and, when cold, it may be given to the child almost *ad libitum*, but in small quantities at

a time. Give the salol in appropriate doses every two hours until there is marked improvement in the bowels, and apply something warm to the abdomen. In the majority of cases the little patient will be ready for food in twenty-four hours. This should then be given in small quantities at first, and it must be of the proper kind.

An important addition to our therapeutic resources is the *ice-water* enema, and it is indicated and used with advantage in all conditions of loose bowels, but it is more especially indicated where there is rectal tenesmus with bloody or slimy stools and an increased temperature. There is nothing which will so promptly relieve the little sufferer as well as the anxiety of the mother.

The manner of giving the enema is important, as it is desired to have it retained as long as possible, and this is sometimes difficult to accomplish in young children unless one understands it thoroughly. It is best for the physician himself to give the enema, at any rate, the first, and, unless he is willing to do this, he need not look for success.

An ordinary Davidson syringe may be used very slowly, but the fountain-syringe is preferable, raised only just high enough to have the water flow in slowly, and at intervals the stream should be checked for a while by pressure upon the tubing.

By proceeding in this way, and holding the buttocks together firmly with a towel over the hand, which at the same time holds the nozzle in the rectum, the child can be made to receive and retain a considerable quantity, if the recumbent position is insisted upon for a few moments after.—*N. Y. Med. Jour.*, Aug. 6, 1887.

Witherspoon (R. G.) on Paracoto in Dysentery.—E. Y., age two years, had been ill of dysentery for four days. I was called at night, June 5th. Found her in convulsions; had her placed in the warm bath, cold applied to the head and gave an enema of warm water, which was retained only a short time. Convulsions recurred about every hour, bowels moving, tormina and bloody mucous discharges, every half hour. Gave calomel and ipecac, and every third hour administered rectal injections of half pint of saturated solution alum in cold water every two hours.

8 A.M., June 6th. Found her almost in state of collapse—skin cool, face pale, very restless, and constant discharge of dark-

green matter from bowels. Gave injection of 20 grains of ipecac in half pint of cold water, after which there was a copious discharge of green matter followed by blood, mucus, etc.

8 P.M. Found her in very much the same condition; stupor, however, had supervened, after restlessness; contracted pupils, bowels still acting and very watery. Gave fluid extract paracoto, ten drops, every four hours.

8 A.M., June 7th. Found patient playing with her dolls; warmer, and bowels under better control.

June 8th, 8 A.M. Find her still improving; convalescent. Continue the paracoto 3 times a day. The case progressed favorably, and at end of two weeks the child was well and hearty.

Fred. T., aged two years. Fell ill June 2d; I was called on the 4th, and found him in very much same condition as previous patient, minus the convulsions.

He had the characteristic dysenteric discharges. Treatment was very much the same as in previous case—injections, ipecac, bismuth, opium in form of paregoric, calomel, quinine, etc. He was relieved of the urgent symptoms in a few days, but diarrhœal, and at times dysenteric discharges continued. I prescribed fl. ext. paracoto, but it could not be had before the little boy went into a condition of marasmus. He died at the end of four weeks of inanition.—*The Medical Age*, July 25, 1887.

Pope (S.) on a New Remedy for Night-Sweats.—I desire to call the attention of the profession to a vegetable remedy, native to our soil, for that troublesome accompaniment of wasting diseases, night-sweats. It is the cinquefoil, *Potentilla canadensis*, called by some botanists *Potentilla sarmenosa*. I have stopped night-sweats with it when *atropine failed to relieve*. It is pleasant to take; when drawn it has an agreeable odor, much like table-tea. The manner of preparation is to pour boiling water on a handful of the vine, leaves, and root. Let the patient drink *ad libitum*.—*Therap. Gaz.*, Aug., 1887.

La Plane on Subcutaneous Injections of Eucalyptol in the Treatment of Pulmonary Phthisis.—The author employs a solution of the drug in liquid vaseline and gives it in about gr. iv. doses. He asserts that it is of incontestable utility in tuberculosis; that it lessens cough,

expectoration, and diarrhœa, and improves the strength and appetite. He considers it by no means a specific, but only claims it to be palliative in its action.—*Marseille Méd.*, June 30, 1887.

Samuels (A. F.) on Apomorphine in Croup.—Knowing the valuable expectorant properties of apomorphine, I determined to give it a faithful trial. Dissolving $\frac{1}{2}$ gr. (pellet form) in six teaspoonfuls of water, I administered a teaspoonful every five or ten minutes until emesis resulted. The second or third dose usually did the work. Where the child was past swallowing it was administered hypodermically (of course in less water). I also found vaseline or clear lard on oil rubbed on the chest and throat a valuable adjunct. The after-treatment is of great consequence, consisting generally of quinine in small doses, with pilocarpine or syrup ipecac, combined with the celery compound.—*Therap. Gaz.*, July 15, 1887.

Bleyer (J. M.) on Dioxide of Hydrogen: its Administration in the Form of Ozonized Vapor in the Treatment of Diphtheria and Diseases of Pharynx, Naso-Pharynx, Larynx, Nose, Pulmonary, and Bronchial Affections. A New Apparatus for the Production and Inhalation of Ozonized Vapor.—For local use—Spray: 2 ounces 15-vol. peroxide of hydrogen for 14 ounces water. Gargle: 2 ounces 15-vol. peroxide of hydrogen for 14 ounces water. Irrigation: 3 to 5 ounces peroxide for 13 to 11 ounces water. Local use: 3 to 10 ounces peroxide for 13 to 6 ounces water. Inhalations: Full strength, 15 volumes. (Do not use any metal inhalers.)

For administration of ozonized vapor: Take two ounces of the 15-vol. sol., and add chemically pure glycerine, one ounce.

For internal use.—Dose of dioxide of hydrogen: From one to three teaspoonfuls of the 15-volume solution in one-half glass of water, three times daily, after meals. For diphtheria in children, without reference to age, two hundred parts of a 10-volume solution mixed with three parts of glycerine pure; a teaspoonful of this mixture every two hours, and in severe cases every hour.

The ozonizer should be made entirely of glass, which is one of the most important factors, on account of the powerful oxidizing effect which this agent possesses over metals of all kinds. Directions for

using this apparatus are the same as for any ordinary spray. For the office it can be used in connection with condensed air, and for home use with the ordinary bulbs. The delivery tubes are made for up, down, and nasal administration.

The *modus operandi* of the peroxide of hydrogen is by yielding up and setting free one equivalent of oxygen, which, no doubt, is in a nascent and hyperactive state, leaving behind simple water. The difference in the peroxide of hydrogen and oxygen treatment is that the peroxide of hydrogen is the most active. I have applied a two-volume solution spray of the peroxide of hydrogen on a post-pharyngeal abscess, and found at once its powerful action; in comparison, I applied on other ulcerations oxygen gas, and hardly any changes upon the ulcers were seen. The peroxide of hydrogen turns the ulcers perfectly white, and the decomposition of the pus and curative effect could be seen almost immediately. Peroxide of hydrogen should be kept at a temperature below 65° F.—*N. Y. Med Record*, Aug. 13, 1887.

Boone (D. W.) on Atropia Injections for Gonorrhœa.—Where gonorrhœa is accompanied with much vesical irritation, frequent urination and tenesmus, I find the symptoms speedily relieved by an injection of $\frac{1}{4}$ to $\frac{1}{2}$ gr. of sulphate atropia, in one or two drachms of water, pressed along the urethra into the bladder. I have resorted to this method in several cases with the happiest results. I also used it in a patient who had taken an over-dose of cantharides, which produced great vesical tenesmus and pain in passing water. One injection gave immediate relief. I leave the injection in the bladder, and have never seen any poisonous effects from the drug. I think it superior to the salts of cocaine, as the effects are more lasting.—*Med. and Surg. Reporter*, Aug. 6, 1887.

Stewart (T. G.) on Diet in Albuminuria.—In the albuminuria going with inflammatory Bright's disease the author advises milk or low diet. In cirrhotic Bright's disease with acute exacerbations the quantity of urea or albumen was influenced by a milk diet. In pure cirrhotic disease of the kidney he considers diet of less importance than in parenchymatous cases.

In cases of amyloid disease he does not consider a generous diet contra-indicated.

In febrile albuminuria a low diet is indi-

cated even during convalescence. The albuminuria due to *heart disease* is, as a rule, comparatively slight, and in the presence of the organic changes in the circulatory system, scarcely deserves attention.

Albuminuria due to digestive derangements is necessarily influenced by the kind of food which produces the disturbance in each particular case, and the effect of different diets upon the albuminuria must depend on the effect they have on the digestive derangement.

Albuminuria connected with *nervous disease* and with *glycosuria* also demands little attention in this respect. There thus remain only the functional and accidental groups for consideration.

As to the four great varieties of *functional* albuminuria—the paroxysmal, the dietetic, that due to exercise, and the simple persistent—the first requires no special notice. Of the second it is obvious that each individual case must be studied, and the diet prescribed for the patient in accordance with what may seem best to suit his individual peculiarities. In some cases referable to the third group—that of albuminuria from exercise—a careful trial of different kinds of food caused little alteration.

From this and similar cases the author is inclined to think that little is gained by very special dieting in cases of simple persistent, but that the physician should keep his eye upon the effect of any particular food in each individual case.

In the treatment of *accidental* albuminuria, diet is often, as most practitioners well know, of great importance. Above all, in cases of catarrhal inflammation of the urinary tract, bland and milky diet is to be recommended. Great advantage often accrues in such cases from the adoption of an exclusively milk diet. In some of the accidental cases of course ordinary dietetic arrangements are best.

As to the use of alcoholic stimulants, it is best to avoid them in all the forms of Bright's disease and in cases of inflammatory accidental albuminuria, unless when the condition of the circulation or nervous system directly requires stimulation. The author has not seen alcohol prove injurious when used in moderation in circulatory albuminuria, nor in the other less dangerous groups.—*Practitioner*, Aug., 1887.

Taylor (C. S.) on the Physiological Action of Colchicum on the Kidneys of the Gouty and Rheumatic.—From

experiments the author concludes that the urea and uric acid are increased in proportion to the time that the medicine is continued.

These analyses show to what extent colchicum will alter the renal secretion, by supplying it, when deficient in its normal constituents—urea and uric acid—from the blood. To this property of colchicum its remedial action is in a great measure to be referred. Colchicum has been employed in all forms of the disease, but it appears more particularly useful in articular rheumatism. In proportion as the synovial symptoms predominate or mix themselves distinctly with the fibrous—in proportion as the disease approaches in its character to gout—one may expect to be successful with colchicum.

Large doses are not requisite; 20 minims of the tincture of the wine may be given every six hours until some relief be obtained, or a grain of the inspissated juice or of the acetic extract of colchicum every four hours. Under this treatment the disease sometimes vanishes within three days, the medicine producing sickness and purging, and the rheumatism or rheumatic gout rapidly declining; occasionally, the same favorable event takes place, although there has been no disturbance of the stomach and bowels.

The cases in which colchicum appears to be more pre-eminently useful are those in which the disease attacks the joints and is of an erratic character, for example, suddenly disappearing from one joint, and as suddenly appearing in another; these are the cases in which the heart and other internal organs are chiefly affected, and probably if the active operation of colchicum is secured early, these formidable secondary diseases are less likely to occur.—*Br. Med. Four.*, July 30, 1887.

Wright (S. J.), on Naphthol in the treatment of Enuresis.—The case was one of enuresis, without cystitis or calculus or any pain, occurring in a neurotic lady thirty-four years old. The condition had existed since childhood. No relief had been found in local or general treatment. She had been obliged to rise many times every night for years. The quantity of urine passed each time was small, the total amount for the twenty-four hours being about three pints. A nervous cough had lasted a year in spite of treatment, and, fearing bacterial infection, the doctor gave

her a No. 2 capsule filled with naphthol, also using the drug in the form of a spray. The enuresis rapidly subsided during this treatment, although no change was visible in the appearance of the urine. A temporary cessation of the naphthol for a few days was promptly followed by a return of the enuresis, which again left on resuming the drug. She is now free from enuresis, and can sleep better than ever before. Her throat gives her no pain, her cough is nearly gone, and she can omit naphthol without a return of her enuresis.—*N. Y. Med. Record*, July 30, 1887.

Gaddy (N. D.) on the Treatment of Hæmaturia with Hamamelis Virginica.—The author has used the fluid extract of the hamamelis in doses 3 ss-3 j every three hours until relief of pain is obtained, and then the remedy is given three times a day only. This has to be continued one to four weeks, or until the hemorrhage, etc., were completely cured.

It is not to be supposed that witch hazel will alone cure all cases of hæmaturia any more than that quinine will alone cure every case of intermittent fever, but it has thus far proven very satisfactory, in the author's experience, whenever it was properly used, in relieving the pain that was so severe that it caused strong men to cry out in loud and repeated expressions of most intense suffering. A few doses of a teaspoonful each were sufficient to mitigate the suffering, and to encourage hopes of perfect cure by its further use.

While it is a remedy of utility when given to meet its specific indication, yet he regards it as being capable of doing a great deal of harm when the state of the system is not in proper condition for its use. Among the chief contra-indication against its use, is the presence of subacute or acute congestion or inflammation of any portion of the body of a sthenic character.—*So. West. Med. Gaz.*, Aug., 1887.

Brown (J.) on the Prophylactic Advantages of the Early and Continual Inunction of Carbolized Oil in Scarlet-Fever.—Experience has proved that scarlet-fever generally attacks every inmate in the home who is susceptible to the contagium, or who has not been protected by a previous attack. The contagium is spread chiefly by the peeling of the epidermis. Any treatment which can destroy the germs and prevent the dissemination of the skin must prove a valuable prophylac-

tic. The treatment which I have carried out for a period of nine months partially, if not effectually, fulfils these two things. The success has been very satisfactory, although the treatment has not been rigidly carried out in all its details; this applies particularly to the operative class, who have not the time to do all that they would.

Treatment.—As soon as the rash is out, apply carbolized oil all over the body, except the face, over which apply olive oil. Let this be done twice a day, with a warm bath every night. Continue this treatment until the fourth to the sixth week, when we may hopefully expect to have prevented the spread of the disease. The carbolized oil contains 5 per cent. of carbolic acid. It is important to have the pure medicinal carbolic acid and the best olive oil. The patient should not be exposed during the process; the temperature of the room should be 65°; the hand must be warm. In a severe epidemic of scarlet-fever, the Town Council adopted my recommendation, and provided carbolized oil for free distribution. In twenty-five consecutive cases taken from my note-book, there was not one death, no case of renal dropsy, nor any sequelæ of any importance. There were five cases between one and five years, fifteen between six and twelve years, and one adult. The *rationale* of the treatment may be summed up as follows: Carbolic acid is an antiparasitic, and probably destroys the vitality of the germs; it also acts as a sedative to the skin by its anæsthetic action on the sensory nerves, and thus conduces to the comfort of the patient. Pure olive oil arrests the desquamation of the skin, which is removed by the daily warm bath. It probably assists in the earlier desquamation of the skin, and also prevents the susceptibility to chill during the convalescent stage by forming a thin covering for the skin, and thus warding off the tendency to renal dropsy; it conduces to sleep by allaying the irritable itching of the skin, and gives a sense of coolness which many patients highly appreciate, especially in the early period. The oil prevents the free access of air to the skin, and may thus attenuate the virulence of the contagium. If properly carried out there are no dangers in the treatment. In no case has it produced any unpleasant symptoms. The carbolic acid has not been absorbed so as to affect the urine.—*Brit. Med. Jour.*, Aug. 13, 1887.

Quinquand on the Action of Cold on the Living Organism.—From experiments on animals the author shows that progressive refrigeration produces a particular hyperexcitability. There is also a hyperoxygenation of the blood, and an increase of the glycogenic action of the liver with glycosuria, showing that cold baths might be harmful in diabetes. The exhalation of carbonic acid by the lungs is increased at first, lessened when refrigeration reaches a certain point.—*Four. de Méd. et de Chir. Prat.*, July, 1887.

Jacoby (G. W.) on the Treatment of Neuralgia by Means of Intense Cold.—The author sets forth the advantages attending the use of chloride of methyl and liquid carbonic acid. His general impression is that we had in chloride of methyl a reliable analgesic which did not affect the general condition of the patient, and that it is invaluable in the treatment of neuralgia for the immediate relief of severe pain. It is used in the form of spray under high pressure. The objections to be overcome are the expense of the apparatus and the difficulties of getting the drug. From his experience in the use of condensed carbonic acid, his conclusions are that, in the absence of chloride of methyl, it is able to take the place of that remedy in the treatment of sciatica; that the pain is relieved very promptly by it, but that its curative effect is not so great as that attributed to the chloride of methyl by other observers.—*N. Y. Med. Jour.*, July 30, 1887.

Rabow on a Familiar Remedy in Migraine.—In the *Ther. Monats.*, April, 1887, the author calls attention to a simple remedy in migraine. He asserts that when the aura of an attack comes on, a half or one teaspoonful of table or sea salt will in almost all cases abort the attack.—*Ann. de la Soc. Méd.-Chir. de Liège*, June, 1887.

Lyman (H. M.) on the Treatment of Progressive Locomotor Ataxia with Rarefied Air, after the Method of Junod.—The author concludes:

I. That progressive locomotor ataxia cannot be cured by dry cupping.

II. That the painful sensations which accompany the evolution of the disease may sometimes be relieved by this method of treatment.

III. That the principal advantage resulting from the use of Junod's cupping apparatus consists in the improved nutrition of

the muscles of the limbs which are subjected to its action.

IV. That the delay of muscular atrophy thus procured is due to the local action of rarefied air upon all the structures of the affected parts, and is limited to the tissues which are actually inclosed within the exhausted receiver.

V. That the improvement of nutrition is, therefore, principally accomplished by direct action, rather than by reflex influences exerted through the spinal cord.

VI. That in the use of rarefied air we employ an agent which is competent to fill a subordinate and limited yet often serviceable position in the treatment of cases that are characterized by a tendency to muscular degeneration.

This, probably, is also true in other diseases besides progressive locomotor ataxia. —*Four. Nerv. and Ment. Dis.*, July, 1867.

TOXICOLOGY.

Larue (F.) on Poisoning by Crude Carbolic Acid; Death from Tetanus on Seventh Day.—Matthew C., æt. 36, while intoxicated in the afternoon of May 27, 1887, by mistake drank some crude carbolic acid from a Holland gin bottle. The ambulance surgeons promptly administered, hypodermatically, one one hundred and twentieth grain of atropine, one tenth grain of apomorphia, and fifteen minims of tincture digitalis, and, by the mouth, liquor calcis saccharat. Arriving at the hospital, the stomach was well washed out by means of the syphon-tube, with warm water first and afterwards with sweet oil in liberal quantities. The odor of carbolic acid in the washings was decided, but it could not be ascertained how much had been swallowed. The patient now complained of great pain and tenderness in the epigastrium, and became exceedingly restless and frightened. Morphia was given hypodermatically from time to time, and crushed ice was freely allowed. Examination of throat revealed no signs of severe action of the acid, being only slightly whitened in a few spots. Sweet oil, mucilaginous drinks, sweet milk and morphia were given occasionally during the night.

May 28th, morning.—Great pain and tenderness in epigastrium; frequent violent retching; felt as though his head would burst; eyes injected; urination rather pain-

ful and scanty, only eight ounces of blood-colored urine being passed since his admission; very much frightened and inclined to be hysterical; effects of whiskey about disappearing; odor of acid still detected in breath. Continued morphia, ice, olive oil, and ordered the following:

℞ Bismuthi subnitrat	3 i
Tr. opii	3 i
Mucilaginis	ad ʒ vi.

M. Sig. Tablespoonful every half hour.

29th—Somewhat better, but still suffers from the epigastric pain and retches occasionally; urine scanty, only eleven ounces in thirty-seven hours. Continued treatment.

31st—Urine continues scanty and highly colored; otherwise much improved and wants to get up, but is advised to keep quiet. The improvement continued until the afternoon of June 1st, when the student of the ward was called at 2:30 P.M. Patient was then very much excited, and said he could n't open his mouth; said he was going to have lock-jaw. He complained of pain in the back of the neck and of a numb feeling in right arm. The condition seemed to have developed very rapidly, and it was thought it might be hysterical, but at night the symptoms had deepened, the pain being intensified, the jaws more tightly locked. Potassium bromide and chloral were ordered every four hours. At midnight patient became worse, and the student of the ward directed the sedative every two hours, with morphia, one eighth grain in each dose.

June 2d, A.M.—Opisthotonos, dysphagia, with spasmodic action of pharyngeal muscles: teeth tightly clenched; was afraid he would choke; spasm of thoracic muscles made breathing difficult. In spite of all treatment, he became rapidly worse and died at 10 P.M. in a violent convulsion.

Autopsy, held by Dr. Archinard six hours after death, showed the following: Slight inflammation of pharynx and upper part of œsophagus; stomach and intestines normal; heart dilated and full of fluid blood; lungs congested; liver cirrhotic, hob-nailed; kidneys fattily infiltrated; spleen usual size; arachnoid and pia mater of brain and upper part of spinal marrow congested; congestion more marked over motor area of brain.—*New Orleans Med. and Surg. Jour.*, Aug., 1887.

Bidwell (E. H.) on Pilocarpine Poisoning.—When I was a second-year medical student my room-mate, a drug-

gist, wishing to "break up a cold," asked my advice as to the best diaphoretic. Following my instructions he took two drachms of the fluid extract of jaborandi and went to bed. In about half an hour, when I followed him up-stairs, I found him suffering with profuse perspiration and salivation, dimness of sight, prostration, a sensation of cold, tremors, and extreme general nervousness. I was too much frightened to take his pulse or temperature or note the state of the pupils. I hastily consulted all the authorities at command, but without getting any help from them. While I was trying to decide what to do, all the symptoms suddenly passed off, excepting only the perspiration, which persisted, though in a moderate degree, for several hours. The duration of alarming symptoms was certainly not over an hour and a half, probably not more than an hour from first to last. No effect of the jaborandi was perceptible on the following day.—*Med. News*, Aug. 6, 1887.

Bevill (C.) on Santonin Poisoning.—My first case was a girl of six years. She presented every symptom of worms. I gave two-grain doses morning and night for two days and nights, taking care to move the bowels every day. On the morning of the third day the child had convulsions. There had been three convulsions before my arrival, and only one after. A large dose of castor oil had been given as soon as the child could swallow it. The bowels moved freely in two or three hours, and the symptoms of convulsions were all over. Sixty large worms were expelled within twenty-four hours.

I thought for a day or two that it was only the worms that produced the convulsions, but I noticed the conjunctivæ were of a yellowish-green color, and the child could not see well. After a few days the eyesight got all right.

The second cases were in the year following. Two children in one family were treated for worms by the mother, under some directions from their family physician. On the third morning I was called to see the children, "with fits," as they called them. Stimulants internally, heat to the extremities, a copious enema, and such measures as were calculated to keep up the circulation, were used.

The kidneys were secreting but little urine. The pupils were dilated.

After some hours' work the bowels moved

and kidneys acted well, and the children got up, but no worms were passed.

The drug had been given in these cases in conjunction with calomel and sugar. I do not know in what amounts.

The next case was a little boy, seven or eight years old. He was taken ill during my absence, and another physician was called to see him, and he gave calomel and santonin, three doses, three grains of the latter to four or five of the former.

The bowels never moved for forty-eight hours, and as soon as I arrived home I was called to see the little fellow. His limbs were flexed, bathed in cold sweat, pulse 150 to 160, respirations jerky, pupils dilated, jaws set, abdomen swollen, and comatose nearly all the time. I could do but little—stimulants rubbed on the spine, plenty of warm water and soap enemas, poultices to the abdomen, blister to the nape of the neck, etc. After a while the bowels moved copiously; green, offensive matter.

At the end of five hours he could talk, move, and swallow water. The urine was very scanty and high-colored. By the use of diuretics his kidneys assumed their normal functions.

I was indeed very much puzzled over this case until I found that the child was very nearly blind for over a week. Everything was yellow to him for some ten days.

I find it will not do to give santonin to children while they have high fevers, or when the bowels are costive. If given with castor oil and sugar mixed together it does much better.—*Therap. Gaz.*, June 15, 1887.

Brick (P. L.) on Poisoning by Aconite; Recovery.—A man of twenty-eight swallowed *seven* drachms of the tincture of aconite; treatment was instituted in ten minutes; he walked across the street and stumbled up a pair of stairs, his legs being very weak; complained of burning of the tongue and throat, pressure under the sternum and analgesia; could not feel prick of hypodermic needle; pulse was slow, skin dry and cold, and even breath seemed cold; shivering, nervous tremors and great restlessness; frequent movements of stretching, almost tetanic in appearance.

About two hours after swallowing poison lost consciousness temporarily, while in seven hours sensibility began to return and sleep supervened, from which he awoke

thirsty, with some occipital pain and slight fever, but with some appetite.

During treatment the patient took hypodermically, $\frac{1}{2}$ gr. morphia, 6 drops ext. fl. digital., $\frac{1}{160}$ gr. strychnia, $\frac{1}{3}$ j brandy; *per orem*, 2 gallons warm water, 11 pints coffee, 3 pints whiskey, 20 drops ext. fl. digital., $\frac{1}{2}$ drachm ext. fl. nux vom., $\frac{1}{2}$ pint port wine.—*Fr. Am. Med. Ass'n*, May 21, 1887.

Birt and Jalland on a Case of Poisoning by Chloride of Zinc with Absolute Destruction of the Stomach.—A man of thirty-three took three or four ounces of a saturated solution of the impure chloride of zinc. For over three months he suffered from symptoms of aggravated inflammation of the throat, œsophagus, and stomach. While apparently convalescing he overate and died in a few hours,—cyanosis, dyspnœa, a feeble pulse, and collapse being the later symptoms.

The autopsy was performed thirty hours after death. On reflecting the abdominal parietes, nothing could be seen of the stomach, and on drawing aside (that is drawing outwards) the spleen from a thickened mass in the position of that viscus, some inflammatory adhesions were broken through, and a small abscess-cavity the size of a hazel-nut, with grayish walls, containing a little reddish pus, was opened. The stomach was found to be represented by an organized inflammatory matting of the gastro-hepatic omentum, and the upper portion of the great omentum, both of which had left their characteristic shining appearance, to the adjacent viscera, as follows: behind and below to the pancreas, the pillars of the diaphragm, and the vertebral column; above, to the under surface of the left lobe of the liver; on the left side, to the upper portion of the inner surface of the spleen, which was drawn inwards into the epigastric region of the abdomen; and on the right side, to the under surface of the left lobe of the liver.

With great difficulty, owing to the adhesions, this mass was removed with portions of the neighboring structures adhering to it, and on examination no traces of the muscular, mucous, or serous coats of the stomach could be found in it; it seemed to consist entirely of an irregular, sausage-like mass of organized, inflammatory, peritoneal adhesions, about five inches in length and four inches in circumference, its outer surface was very irregular and ill-

defined, grayish-brown in appearance, much resembling a pleuritic adhesion. On opening this mass no trace of a mucous membrane could be seen between the termination of the œsophagus and the commencement of the duodenum, which was dilated to the size of half a crown, the general appearance of the cavity being much like that of a chronic abscess. In size it measured four inches from the œsophagus to the duodenum, and about three quarters to one inch in diameter, there being an irregular constriction about the middle of the mass. The walls of the mass were thin opposite the liver and the spleen, but about the pancreas and the attachment of the great omentum they were three quarters of an inch in thickness. The common bile duct and the cystic duct were not involved, and opened into the duodenum as in the usual position. Beyond the lesion above described there were no evidences of a past attack of general peritonitis, no cicatricial contraction of the œsophagus or pharynx, and, with the exception of a slight congestion of the bases of both lungs, the other viscera were perfectly healthy.—*Br. Med. Jour.*, June 25, 1887.

MEDICINE.

Bouveret (L.) on Dilatation of the Cæcum and Ascending Colon.—The writer has had two cases in which he thinks the above is the pathological condition. The symptoms are alternate diarrhœa and constipation, colicky pains starting from the right inguinal region, running up toward the liver and confined principally to the right side of the abdomen though radiating occasionally all over it; manifest hyperperistalsis in the right side of the abdomen with tympanitic or fæcal distension of the same region.

In one of his cases, dying of marasmus, he found a circular epithelial growth almost occluding the colon at the junction of the ascending and transverse portion.

In the other case, a victim of biliary colic, the author thinks that repeated distension of the gall bladder had set up a localized peritonitis in the region of the right angle of the colon, which, by its contracting lymphoid exudations, tended to constrict the colon at this point. Any obstacle at this point would especially tend to

cause atony and dilatation, aided by the gravity and the resistance of the ileo-cæcal valve.—*Lyon Méd.*, July 31, 1887.

Sawyer (J.) on the Treatment of Gastralgia.—Before you prescribe you ought to find out if there be any prominent pathological concomitants or causal antecedents of the disorder, and deal with them. Anæmia, sexual excess, overwork, work under wrong conditions, uterine discharges, masturbation, etc., must be appropriately met. But for the cure of the gastralgia something more is usually necessary. Of all the directly therapeutic results in medicine with which I am acquainted, one of the most demonstrable is that which can be produced by the suitable exhibition of arsenious acid in uncomplicated gastralgia. I give one twenty-fourth of a grain of arsenious acid, made into a pill with two grains of extract of gentian, thrice daily, between meals. The use of this remedy must be continued for a few weeks. In a case of moderate severity no other medicinal treatment is necessary. The gastralgic pains become less frequent and less severe, and recovery is steadily and surely attained. In severer cases I use some form of counter-irritation to the epigastrium, and I usually employ a rubefacient liniment of ammonia. In the severest cases vesication by a fly-blisters is of service, and the blistered surface should be kept raw for some days by means of a daily dressing of savin ointment. But you must not rely upon treatment by drugs alone. Every hygienic adjuvant which tends to raise the strength of the patient is of high value in the cure of gastralgia. I especially advise you to make sure the sufferer feeds well and fully. The diet should be generous.—*Lancet*, Aug. 13, 1887.

Collier (M.) on the Duodenum: A Syphon Trap.—We may take it for granted that all gases generated in the jejunum, ileum, and large intestines pass onwards towards the anus, and there sooner or later escape. Fetid gases—except those generated in the stomach and duodenum—never pass upwards, not even during vomiting due to hernia, obstruction, and other causes. Physiologists, it would appear, have never busied themselves to find an explanation for this apparent breach of the laws of gravity. The intestinal canal is a tube with various dilatations and constrictions, but at no spot except the pylorus does the constriction completely obliterate

the lumen of the tube, and here only periodically. It is perfectly evident, then, that, unless some system of trap exists in the canal, gases are free to travel from below upwards in obedience to the laws of gravity, and would, as a matter of fact, sooner or later do so. From the straight course and vertical position of the œsophagus, a very slight pressure of gas in the stomach easily overcomes the closure of its cardiac sphincter and allows of escape. When the stomach has digested its contents and the pylorus is relaxed, gases generated in the duodenum can and do ascend into the stomach and so escape. Normally no foetid gases are generated in the stomach or duodenum. If we follow the course of the intestines down, we find that the duodenum presents a remarkable curve.

Now, there are some points of great interest in connection with this remarkable, almost circular, curve of the duodenum. In the first place, this curve is a constant feature in all mammals. Mr. Treves says it is one of the most constant features in the anatomy of the intestines in man, and, speaking of mammals in general, that the curve of the duodenum varies in shape, but is never absent, becoming more complex in some of the higher primates, but seldom less distinct than in man. In birds the duodenum always forms a long loop embracing the pancreas.

A second point of great interest is the absolute constancy and fixation of its terminal portion at that point of junction with the jejunum, more correctly termed second ascending or fourth portion. Mr. Treves says that this fourth portion is never less than an inch, and is practically constant. It extends along the side of the left crus of the diaphragm opposite the second lumbar vertebra, and is there firmly fixed to the front of the aorta and crus of the diaphragm by a strong fibro-muscular band, slinging it up and absolutely retaining it in position. This band has been termed the "musculus suspensorius duodeni," but is chiefly composed of white fibrous tissue, and is more of the nature of a ligament than a muscle. This ligament is always present, and its position is never altered. The curve of the duodenum may descend as far as the iliac fossa, but the terminal portion is always maintained by this band in its normal position.

Another point of great constancy is the position of the pancreas and its relation to

the curve of the duodenum. The duodenum always curves round the head of the pancreas, and is, as it were, moulded on it and retained in position by it. In birds the duodenum always forms a long loop embracing the pancreas. Further, the ducts of the liver and pancreas always open into the centre of the duodenum, either separately or by a common opening.

Now, the absolute constancy of the curve of the duodenum, the complete fixation of its fourth portion, the position of the pancreas, and the place of entry of the ducts of the pancreas and liver, are all component parts of a syphon trap, whereby gases generated below the duodenum are prevented from passing upwards. The duodenum, then, is a syphon trap, and a most efficient one. Now the efficiency of a syphon trap depends not only on its shape, but what is absolutely essential is that the curve must be kept constantly full of fluid, without which it ceases to be a trap, and would allow gases to ascend freely. The position of the place of entry of the ducts of the pancreas and liver assures that this *sine qua non* shall be present. The discharge of the secretions of the pancreas and liver, although more active during and after feeding, is practically constant, and so ensures in an admirable manner that the curve on which the efficiency of the trap depends shall be constantly kept full, not only with fluid, but, as I would suggest, antiseptic fluid. There is no other trap in the intestinal canal, but the peculiar position of the colon would no doubt have more or less effect in preventing gases ascending through the ileo-cæcal valve.—*Lancet*, Aug. 13, 1887.

Caldwell (J. P. K.) on a Remarkable Case of Fasting from Paralysis of Muscles of Deglutition—Death on the Ninetieth Day.—The patient had endured the hardships of a soldier's life in the Confederate army during the late war, which so greatly impaired his health that he never was fully able to regain it. He was always of an exsanguineous aspect, his appearance being decidedly suggestive of pulmonary tuberculosis, though the closest examination did not reveal the signs of that disease during his last illness. Two or three of the patient's sisters and brothers had been victims of consumption. He was about forty-three years of age, unmarried, and of an eccentric disposition. In February, 1886, Mr. M. was, about two o'clock

in the morning, suddenly stricken with hemiplégia, though some premonitory symptoms had from time to time manifested themselves in the posterior occipital region. The stroke was ushered in with very great pyrexia, the temperature probably going as high as 105° or 106° F.

Since the above-named occurrence the patient has been entirely confined to his room, without any intercourse whatever with the outside world. Again, just thirteen months subsequently to the first, a second and a more severe recurrence of the paralysis supervened, this time wholly prostrating the patient, who had partially recovered from the first attack.

The last attack involved the entire alimentary tract. All the co-ordinating powers of the different muscles of that region seemed to have been destroyed; more particularly those of deglutition, which were involved to such an extent as to render the act of swallowing entirely impossible. He could converse freely, but the act of deglutition was wholly out of the question.

The patient believed himself beyond all hope of succor, and refused all medical assistance, though a number of physicians visited him in a friendly way and watched his case.

His temperature at no time was above normal, the skin being moist and cool, pulse surprisingly good, and respirations quick and natural.

At the time I saw the case it had covered a period of fifty-nine days, in which reliable and altogether truthful attendants stated that he had not been known to swallow any thing whatever, not even water, for the period of time corresponding to the fifty-nine days. I found the patient quite cheerful and feeling comfortable, with the exception of a sense of weakness. He was communicative and seemed indifferent to his severe malady. The temperature was normal, pulse seventy-six, and of extraordinary volume, respiration about sixteen to the minute and easy, tongue clean and moist, secretions all suspended; he had not had an action of the bowels for the preceding fifty-nine days. Emaciation was so complete that on pressing the fingers lightly over the hypogastric region the pulsations of the abdominal aorta could be distinctly felt and counted.

Upon further inquiry, I was informed that a sense of hunger recurred regularly

at intervals of twenty-four hours, only to disappear, unsatisfied, of course. Thirst was even worse at times, but was to some extent quenched by the patient's holding small ice pellets in the mouth, without swallowing any except perhaps a few drops that might occasionally flow down into the larynx, where they caused intense suffering by threatened strangulation. Stricture of the fauces dated from the first of the attack, as did also the want of co-ordination among the muscles of deglutition. The only pain that was noticed was in the left infra-orbital foramen, and no doubt, from the attendant symptoms, it was neuralgic in its character, and had been habitual in the left eye, destroyed some years before.

At this period, owing, no doubt, to general weakness and a consequent asthenopic condition of the retina of the sound eye, amaurosis developed, and later on became so marked that familiar objects were indistinguishable at any distance.

As regards sleep, the most usual time for it was in the early morning, being rarely indulged in during the night.

No stimulants, either direct or indirect, were used, except tobacco, which the patient was addicted to, chewing on an average four or five cents' worth per day during his entire sickness.

This state of things continued from day to day for a period of ninety days, at which time death occurred.

Ninety days without nourishment of any kind; ninety days and no water, save may be a few drops escaping down through the strictured fauces. Eighty days without any excreta whatever passing from the bowels, at which time it is reported a few ounces of offensive muco-pus were known to pass. At times a few drops of urine were passed, in consequence, perhaps, of the small quantity of water that trickled down the throat, and this was quite seldom indeed. The patient remained rational until about the eightieth day, when he gradually became unconscious, and so remained until death occurred on the ninetyeth day.—*Am. Pract. and News*, Aug. 6, 1887.

DeGrange on a Remarkable Case of Round Worms.—Recently a colored woman brought her child, æt. five years, to the out-patient clinic. The child was of average size, rather healthy-looking, not very thin. The mother said he had a most

ravenous appetite; would eat all day long if the food were given him. He was continually picking at his nose. Lately he seemed to be getting crazy. The mother thought he had worms. Six months ago had passed a small round worm. About two weeks ago the boy felt something come up into his nose, but on drawing a deep breath it disappeared. The following was ordered:

R Santonin et hydrarg. chlor. mitis, $\frac{ss}$ gr. iv.

M.—Ft. cht. No. j.

S.—At bedtime.

To be followed by $\frac{ss}$ ss. castor oil early in the morning.

About 6 A.M. a large evacuation of round worms took place. She then gave the oil at 7 A.M.; he passed again a large quantity of worms. The mother brought them all to the hospital. They numbered one hundred and forty-five lumbricoid worms, averaging in length from nine inches to a foot and a quarter. Many of the worms showed on their sides young in various stages of eruption. The mother said the boy was at stool when she left for the hospital. These worms in alcohol nearly filled a quart bottle.—*New Orleans Med. and Surg. Jour.*, Aug., 1887.

Andrews (E.) on the Cure of Fistula in Ano without Operation.—If one wishes to try the completely non-operative plan, the best method of procedure is as follows: First, explore the interior and ascertain that it is simple enough to give the prospect of being able to make the injections reach all parts of it. Next, bear in mind that this fistula must have a free external opening, otherwise it will confine a quantity of septic pus in the interior, which, both by mechanical distension and irritant qualities, will arrest all efforts at healing. It is therefore best in many cases to enlarge the external portion of the sinus with a bistoury or with a laminaria tent. This being accomplished, inject the whole interior of the fistula carefully with a good vigorous article (for that sold in the shops is very variable) of hydrogen peroxide. It will be better to inject this through a small catheter inserted into the deepest parts of the channel, or else throw it in by a syringe whose beak is large enough to completely fill the fistulous opening, so that the pressure shall compel the fluid to find its way into the remotest parts. Throwing the solution in repeatedly, and giving it time between the pulsations of the syringe for

the foam produced by the action of the medicine on the pus to boil freely out, we next leave the patient quietly on the lounge an hour or two. Then with a small syringe insert about 10 minims of a solution of bichloride of mercury of the strength of one part to 3,000 of water. Repeat this once in about three or five days, taking pains not to throw large quantities of irritating solutions through into the rectum. This procedure alone will cure a considerable proportion of cases. But if greater thoroughness is required, some advantage will be gained by taking Allingham's rectal speculum, and, exposing the internal orifice of the fistula, touch the opening with a stick of nitrate of silver where it enters the rectum, and place the patient in bed with a sheaf of three soft-rubber catheters lying side by side in the rectum to give exit to the gases and mucus. The bowels should be previously emptied with a cathartic.—*Chicago Med. Four. and Examiner*, July, 1887.

Easmon (J. F.) on a Case of Abscess of the Liver in a Child Three Years and a Half old.—About Jan. 1st, 1887, a swelling was noticed for the first time in her right side, and this had been getting larger ever since. Some six weeks before, the patient suffered from "bilious" fever; the fever came on every evening, accompanied with much shivering, and ending in profuse perspiration and the discharge of high-colored yellow urine. She was losing flesh daily, and latterly vomited whenever food was taken. She complained of no local pains and had never had dysentery since she was born, in May, 1883. She allowed her mother to touch the tumor freely, but would not suffer me to get near her for purposes of examination.

I admitted her Jan. 20th into the General Hospital, and put her under chloroform. Examination revealed a large, tense, prominent tumor occupying the entire right hypochondrium, and extending inwards into the epigastric and downwards into the hypogastric regions, with a distinct bulge anteriorly below the ribs. The tumor was dull on percussion, and there were obscure signs of fluctuation. Introducing the finest needle of the aspirator I obtained pus; I now withdrew this and introduced the second largest aspirating trocar and drew out nine ounces of thick yellow pus, odorless and without clots. The abscess cavity (a single large one) was then thoroughly

washed out with ten ounces of a solution of chloride of zinc (half a grain to the ounce), an injection made of successive portions of two ounces at a time, and finally two ounces of the solution left in. An antiseptic pad was placed over the puncture, and a flannel bandage put firmly on around the abdomen and thorax. Complete anesthesia was maintained throughout the operation. The patient was put on beef-tea diet and milk *ad lib.*, with five-grain doses of chloride of ammonium three times a day. At my evening visit I found the patient up in bed and evidently quite contented. She had complained of no pains. The temperature from 97° before the operation, had risen to 99° in the afternoon, but there was no feverish feel about her.

Two re-accumulations of pus took place, giving rise to slight hectic, which subsided after evacuation and washing out of the abscess cavity. Complete recovery ensued.—*Br. Med. Four.*, Aug. 13, 1887.

McTaggart (F.) on the Abortive Treatment of Typhoid Fever.—As I regard the cause of typhoid fever to be a germ which permeates the system through the breathing passage, and deranges the whole alimentary canal, I begin by charging the atmosphere of the patient's room with what I conceive to be antagonistic to the previously inhaled source of the disease; as spirits of turpentine and liq. sodii chlorinati are deadly to animal and vegetable parasites, the air is well charged with these. The former is not only destructive to disease germs, but is, when sprinkled about the room, productive of ozone. Be this as it may, a room thus deodorized is better for both patient and attendants. Next, whenever the strength of the patient warrants the procedure, I wash out the stomach with the following preparation, after cleansing with warm charcoal water:

℞	Liq. sodii chlorinati	. . .	f 3 ij
	Vini gallici	. . .	f 3 j
	Aque destil. q. s. ad.	. . .	℥j

M.

The process does so much good and causes so little fatigue, that I withhold it only when life is threatened, or the disturbance is but slight. The washing having been thoroughly but gently done, I give enemata of charcoal water, well charged with the charcoal, and follow the dejections with enemata of sweet oil, to which has been added naphthalin, 15 to 20 grains to the pint. Subsequently the bladder is

washed with warm water holding in solution two drachms of boracic acid to the pint, and one thirtieth of a grain of biniodide of mercury is given every two hours. If diarrhœa is present the mercury is not given; if it comes on the mercury is withheld, and naphthalin is administered in from five- to seven-grain doses every two hours. With an irritable stomach the initial dose should be smaller, till a tolerance of the medicine is established. Failing in this, I select benzoate of soda with ergot, and employ strychnine during the whole course of the disease.

For reducing fever I have found an excellent agent in the nitrate of ammonia. It was suggested to me by Dr. A. B. Stuart, of Santa Rosa, Cal., who with much show of reason ascribes to it still other virtues in the treatment of typhoid fever. It should not be employed with the mercury, nor with Labarraque's solution. Frequent washings of the stomach are not necessary, as the first has already reached the seat of the disease so far as washing the stomach can; and subsequent morbid deposits are dislodged with sufficient frequency by the washing every second or third day. As feculent matter readily accumulates in the lower bowel, the enemata of naphthalin and olive oil are repeated once or twice a day, not forgetting the previous cleansing with charcoal water. Cleansing the bladder or medicating it with the boracic acid solution, is done as often as the condition of the urine indicates. Epistaxis, if serious, may be controlled at once by forcing tincture of benzoin well up the nostril with a small syringe. Injections of equal parts of milk and spts. of turpentine, thrown up well, control hemorrhage from the lower bowel, and act favorably in ulceration. But as it is uncertain whence hemorrhage proceeds, I give by the mouth benzoate of soda with fluid extract of ergot, and a pill of sulphate of copper, quinine, and morphine alternately.

Now, while placing some reliance upon the medication by the mouth here presented, I attribute the abbreviation of the disease chiefly to the other mode of treatment. Not that the adoption of one to the exclusion of the other would prove efficient, but my experience leads me to believe that both combined will abort typhoid fever, if taken at the beginning, and at a later period would be attended

with great success.—*Med. and Surg. Reporter*, July 30, 1887.

Hun (H.) on Sewer-Gas Poisoning.

—From a consideration of twenty-nine cases, the author concludes that it is probable that the following conditions may result from sewer-gas poisoning:

- 1st. Vomiting and purging, either separately or combined.
- 2d. A form of nephritis.
- 3d. General debility, in some cases of which the heart is especially involved.
- 4th. Fever, which is frequently accompanied by chills.
- 5th. Sore throat, which is frequently of a diphtheritic character.
- 6th. Neuralgia.
- 7th. Perhaps, also, myelitis of the anterior horns.

These conditions may occur separately, but are frequently combined, and it is especially common for the fever to be associated with the other forms of sewer-gas poisoning.

Finally, in cases of sewer-gas poisoning there is one group of symptoms which is almost always prominent, and these symptoms are: loss of appetite, drowsiness, extreme prostration, and a dull, unpleasant feeling in the head; and whenever this group of symptoms occurs, not as the result of an attack of acute disease, but as a chronic condition, we are justified in suspecting that the patient is exposed to sewer-gas infection.

If we summarize the cases of sewer-gas poisoning which are scattered through medical literature, and which have been mentioned in the notes to this paper, we find that more or less satisfactory evidence has been adduced that the following diseases may result from sewer-gas poisoning:

8th. Zymotic diseases, such as: typhoid fever, pneumonia, diphtheria, cholera, dysentery, cerebro-spinal meningitis, erysipelas, and scarlet-fever (in these cases undoubtedly the sewer-gas merely acts as a vehicle for the specific germ).

9th. A condition of asphyxia, which, in its severe form, is characterized by coma, convulsions, and collapse.

10th. Puerperal fever.

11th. Abscesses.

12th. Lymphadenitis.

13th. Acute aural catarrh (?).

—*Med. News*, Aug. 20, 1887.

Putnam (J. J.) on a Rare Case of Dystrophy of the Face and Head.—

The case was one probably of hyperostosis of the cranium, occurring in a young woman twenty-one years of age. Her health was apparently good, and there was no history of syphilis; her mother, however, suffered with her head. The first symptoms were severe, and intense pains in her head, enlargement and protrusion of the eye were first noticed about two years after the beginning of the headache. Three years ago her teeth began to fall out, and at the time he saw her she had but one remaining tooth. Two years since a purulent discharge from the ears appeared, and she could not distinguish the sound of a tuning-fork. Two years after the onset of the symptoms she had a miscarriage, and one year later menstruation ceased. There was œdema of the left eyelid, the eyes were extremely protruded, so that more than half the globe projected; there was no evidence of any paralysis of the nerves, except that the tongue moved slightly to one side. There was a well-defined opacity in the upper cortical lens of the left eye, which may be of importance.—*Med. News*, July 30, 1887.

Wiglesworth (J.) on a Case of Uræmic Hemiplegia.—We are so accustomed to look upon uræmic symptoms as having always a bilateral character, that when we meet with a localized paralysis occurring in a patient the subject of old renal disease, we are prone to put it down without further question to occlusion or rupture of a degenerated vessel. That such localized paralysis may, however, occur under these conditions, without any focal lesion being present in the brain, is proved by the following case, which harmonizes with the observations of French writers on the subject:

Bridget C., æt. 59, had been an inmate of Rainhill Asylum for eleven years, her mental condition being one of delusional mania. She suffered from fibroid disease of her kidneys, and had been in feeble health confined to bed for some months previous to the attack now to be described. One morning patient was found by the nurse to be unable to speak, and though in the course of two or three hours a certain amount of speech was regained, her articulation remained very indistinct, so that her words could only be partially understood; there was decided weakness, though not

complete paralysis of the right arm, but right leg was moved freely; tongue protruded straight; almost complete ptosis of left eye, partial ptosis of right; right eyeball directed out and slightly up, left straight; right pupil 2 mm., very sluggish to light, left 3 mm., acts fairly well. Knee-jerks normal. General mental hebetude. The following day she lay in a heavy drowsy condition, though she could be roused to say a few words; right eyeball directed up and out, left out and a little down. Fair power had now been regained over right arm. Six days subsequently it was noted that she lay in a partially comatose condition, and could not be got to respond to questions; still complete ptosis of the left eyelids; a tendency to conjugate deviation of eyes to left; *right arm now quite powerless*, and some deficiency of movement in right leg. Plantar reflex and knee-jerk present on each side. Temperature slightly subnormal. Gradually became more comatose, and died ten days after the onset of the attack.

Autopsy.—The brain was found to be moderately wasted, exhibiting excess of sub-dural, sub-arachnoid, and intra-ventricular fluid, but the most careful examination failed to detect any naked-eye lesion in any part of it; the vessels were in a very atheromatous condition. The pericardial layers were adherent with old adhesions; the left ventricle was hypertrophied; and the kidneys were markedly cirrhotic, presenting very typically the characters of the small, red, granular kidney, the right only weighing $1\frac{1}{4}$ oz., the left $1\frac{1}{8}$ oz.

M. Raymond, who has recently directed attention to this condition suggests the following explanation, which seems to me satisfactory. The serous effusion, which is the consequence of the uræmic poisoning, itself the result of Bright's disease, compresses the cerebral arterioles, which are already weakened by degenerative changes, and hence slight pressure upon them suffices to disturb the regularity of the circulation in the brain-substance, and to produce paralytic or other effects. In some cases arterial degeneration affects some vessels more than others, and those the least weakened by disease are able to resist the pressure of the surrounding serous effusion, while those more extensively degenerated yield to the pressure. In consequence "ischæmia" will be produced in correspond-

ing areas of brain substance, which may be evidenced clinically by hemiplegia.—*Liverpool Med.-Chir. Jour.*, July, 1887.

Starr (L.) on Croupous Pneumonia of the Apex Attended by a Unique Symptom.—The patient was a boy of four. The peculiar symptom in this case was the decubitus.

When first seen the little patient's condition was as follows: face drowsy in expression, a slight herpetic eruption on lips, and a bright circumscribed flush on the right cheek; decubitus right lateral, with the head markedly detracted, the neck stiff, the spine arched forward, the arms pressed close to the sides and folded across the chest, the thighs drawn up towards the abdomen, the legs flexed on the thighs and the feet crossed,—a decided *en chien de fusil* position in fact; tongue heavily coated, breath offensive, no vomiting, bowels active, and abdomen rather distended; respiration 40 per minute, with active nostrils, grunting expiration, and frequent hacking cough; pulse 140, regular and quick; skin dry; axillary temperature 104° F.; no *tache cérébrale* nor hyperæsthesia; urine scanty and heavy with lithates; cerebral activity blunted, but patient readily roused; well-marked physical signs of consolidation of the upper lobe of the right lung.

The case terminated in perfect recovery.—*Therap. Gaz.*, July 15, 1887.

DISEASES OF THE NOSE AND THROAT.

ABSTRACTS AND SELECTIONS BY CHARLES H. KNIGHT, M.D.

Nasal Vertigo.—In a memoir, read at the French Congress of Laryngology, etc., Joal narrates nine cases of *nasal vertigo*, an affection quite different from Ménière's disease, and independent of aural lesion. He believes in its positive existence as a genuine reflex, like the gastric, laryngeal, and uterine, having its origin in the trigemina filaments supplying the mucous membrane of the septum and of the turbinated bodies, thence being transmitted to the vaso-motor nerves through the sphenopalatine ganglion, whence arise circumscribed anæmia of the brain and vertigo. The affections which give rise to vertigo are: (1) nasal flexions (odors, irritant va-

pors, snuff, flowering grasses); (2) acute coryza; (3) chronic catarrh, especially the hypertrophic form; (4) mucous polypi; (5) post-nasal catarrh. Very trifling nasal affections sometimes produce it, it is most frequent in arthritic subjects, it may occur alone or be accompanied by other nervous phenomena, and it disappears with the cure of the nasal lesion. In every individual suffering from vertigo it is therefore important to examine the nasal fossæ.—*Jour. of Laryngol. and Rhinol.*, July, 1887; also, *Union Médicale*, July 5, 1887.

New Procedure for the Extirpation of Adenoid Vegetations.—Löwenberg having abandoned his crushing forceps, which have been found apt to damage adjacent healthy tissue, has devised a new instrument for the removal of these growths. It consists of an oblong ring-shaped knife, the inner margin of the ring having a cutting edge, and the whole instrument, which is fixed in an oblong handle, being curved so as to adapt itself to the vault of the pharynx. A curved metallic plate is attached to the anterior aspect of the ring-knife, the two being separated or approximated by a sliding mechanism. It is the opinion of the author that the growths need to be removed only sufficient to permit nasal breathing and restore the function of the Eustachian tubes. With this instrument it is impossible to do damage, and it may be used without the aid of the finger or rhinal mirror, after preliminary inspection and palpation.—*Lond. Med. Record*, July, 1887.

In the *Australasian Med. Gaz.*, June, 1887, W. Austey Giles gives the notes of two cases of post-nasal vegetations operated upon with Woakes' modification of Löwenberg's forceps and Meyer's ring knife. The patients were etherized and placed in the recumbent position with the head hanging well down over the end of the table. The writer thinks this method adds greatly to the ease and comfort of the operator. No blood finds its way into the larynx, and the operation may be completed at one sitting.

In the *Four. of Laryngol. and Rhinol.*, July, 1887, Dr. Bronner is quoted as preferring cocaine to general anæsthesia. He has found Dalby's steel nail very useful (see *London Lancet*, Oct. 2, 1886).

Hutchinson (J.) on a Form of Inflammation of the Lips and Mouth, Which Sometimes Ends Fatally, and

is Usually Attended by Some Disease of the Skin.—The paper contained the description of a disease (not, it is believed, previously recognized) in which superficial ulcerations occur in the lips and in various parts of the mouth, followed sooner or later by some form of skin disease and tending to a fatal termination. The form of skin diseases may vary, but the hands and feet were the parts usually affected, and the nails were especially prone to suffer. In some instances the eruption might consist of bullæ, which were followed by free papillary outgrowths. The patients attacked were usually in middle life, or in early senile periods. No special antecedents could be alleged as the probable cause of the malady. Unless checked by treatment, the disease appeared to run its course in about six months, producing death by exhaustion. There seemed reason to believe that opium given in repeated doses will cure it, and that there was, at any rate in some cases, no tendency to relapse afterwards. All the best marked cases as yet observed had occurred in males, but in several milder ones the patients were women. Of the most characteristic, two were master tanners, one a farmer, one a clergyman, and one a gentleman of no occupation; all these resided in the country. Careful inquiry has failed to support the suspicion that the disease might perhaps be due to contagion from animals. Of these five cases two ended fatally and three in recovery. The patients who died were those first observed, and since the discovery of the signal efficacy of opium, no case has ended in death. The observation as to the efficacy of opium was simultaneously made by the President of the Society, Mr. Pollock, and by the author, two different patients being at the same time under their separate treatment and recovering under this drug. Since that every case had yielded if the dose of opium were sufficiently pushed. In one, however, the disease did not yield quickly, and for more than a month seemed likely to end in death. As regards permanency of cure, in one case the patient was known to be quite well four years after his recovery; in another there was reason to believe that such was the fact; and in the third a period of two years had elapsed. In two of the milder cases, occurring in younger patients, the disease had repeatedly recurred. A great variety of remedies had been tried without

benefit before the use of opium was resorted to. In no single case had there appeared to be any tendency to spontaneous improvement. In all cases the inflammation of the lips and mouth took definite precedence of the skin symptoms, and in some the latter were very slight. It was not known that any case had as yet been obtained amongst the poorer classes of society. The author desired to abstain for the present from expressing any detailed opinion as to the causes or nature of the malady. He would, however, venture to suggest that it was allied to other forms of disturbed health attended by skin disease and occurring in early senile periods, such as certain peculiar varieties of psoriasis, pemphigus, lichen planus, and pityriasis rubra. In confirmation of this suggestion, and as an appendix to the paper, a case was narrated (with a portrait in illustration) in which an elderly lady had a kind of spreading eczema-psoriasis of the hands and scalp. She lost her nails and all her hair, and was rapidly failing in health in spite of various measures of treatment, but finally recovered quickly and completely under opium. Her case did not belong to the group described in the paper, because she never at any time had inflammation of the mouth.—*Brit. Med. Jour.*, June 18, 1887.

Malignant Disease of the Tonsil.

—At a meeting of the Academy of Medicine in Ireland, Mr. Henry Gray Croly read a paper on primary sarcoma of the tonsil, and gave the history of two cases. The first occurred in a boy seventeen years of age. The tumor involved the left tonsil and the soft palate, and so closely resembled tonsillar abscess that an incision was made. The patient suffered from dyspnoea and dysphagia. Soon a swollen gland appeared in the left digastric space. Preliminary tracheotomy was followed by marked improvement in the local symptoms, which soon, however, recurred. The swollen gland was excised, and the diseased tonsil and part of the palate were removed by means of the benzoline cautery. The disease promptly returned, and the patient died five months later. The second case was that of a man over fifty years of age. The sarcoma was confined to the tonsil, and so much did it simulate tonsillar abscess that an incision was made into the tumor. Operative interference was declined on account of extensive glandular infiltration, and the patient soon died of

exhaustion from repeated hemorrhages.—*Med. Press*, June 22, 1887.

Simple Amygdalitis and Bicarbonate of Soda.—Rovira y Oliver, of Barcelona, has reached the following conclusions regarding this subject :

1. The simple forms of amygdalitis are superficial from the beginning to the end, or superficial in the beginning, but soon advancing until they become parenchymatous ; or they are deeply seated from the commencement.

2. The anginae disappear within twenty-four hours by dietetic means.

4. The application of bicarbonate of sodium, over a superficially or deeply inflamed tonsil, by neutralizing the acidity and retention of the mucus discharged by the follicles, does not fulfil more than a secondary indication.

4. In this manner bicarbonate of soda may expedite the cure of catarrhal and parenchymatous tonsillitis.

5. Bicarbonate of soda cannot be relied upon as an abortive method of treatment of anginae of the first group.

6. The action of the soda salt is not efficacious in impending anginae of the second group—the advance of the catarrhal to the parenchymatous state.

7. When the stroma of the gland has been affected, bicarbonate of soda can produce a cure in from three to seven days.

8. These effects of bicarbonate are attained by making the applications every two or three hours.

9. It is useless, and may even be dangerous, to apply it, as Dr. Gliné recommends, every five minutes.

10. A few styptic drugs, such as sulphate of alumina, are more efficacious than bicarbonate of soda.—*Journal of Laryngology*, June, 1887.

In the *Brit. Med. Jour.*, April 9, 1887, W. J. Baker strongly advocates the use of bicarbonate of soda.

Erysipelas of the Pharynx and Larynx Epidemic and Sporadic.—Dr. Bedford Brown recommends prompt and extensive cauterization by means of sinapisms applied thoroughly around the neck, over the chest and back, covering the scapulæ. When there is extreme rise of temperature, with delirium and a tendency to cerebral complications, salicylate of soda and of ammonia have been found useful. Two cases are cited.—*Journal Amer. Med. Ass'n*, July 2, 1887.

Thyroidectomy.—Dr. Frank Hartley reports a case in which he operated by Kocher's method. An attempt had been made to cure a colloid cyst, in a woman, 47 years old, by incision and scraping with Volkman's spoon. An obstinate sinus remained, and the remnant of gland was liable to frequent exacerbations of inflammation. A resort to more radical measures was therefore deemed justifiable. The wound healed completely within a month.—*N. Y. Med. Jour.*, July 16, 1887.

A Case of Angioma of the Pharynx.

—This unique case is reported by R. Norris Wolfenden : The patient, a young girl, aged 25, of good general health, occupied as a nursery governess, was sent to me on October 25, 1886, for advice as to the condition of her throat. What had attracted the attention of a suburban practitioner was a swelling in the front of the neck on the right side, about the level of the hyoid bone, and of the size of a hen's egg. This, however, gave rise to no inconvenience. It was soft, and was thought by us to be of lymphatic nature. Coursing through it could be felt some hard cordy vessels. On the back of the neck, chiefly on the right side and at the level of the pharyngeal tumor to be mentioned presently, there was a collection of hard, superficial, varicose veins. The back of the pharynx presented the most curious aspect. On illuminating the throat, a large angioma was seen to occupy the whole of the right side of the posterior wall of the pharynx, in the pharyngo-oral region. It appeared to spring from the posterior and lateral wall of the pharynx, behind the posterior faucial pillar, was considerably raised above the surface, and extended as far as the middle line of the pharynx. It was knotty, dense, and of purple color. A small portion extended over to the left of the median line. Above, it reached to a little higher than the level of the soft palate, when raised on phonation ; below, the mass extended to the level of the base of the tongue, and, so far as could be seen, some varicose veins extended down towards the œsophagus. The tumor was thus of considerable size, and of remarkable appearance. The tonsils being very small, it was visible on simply opening the mouth. Some tortuous varicose vessels coursed along the right anterior faucial pillar and along the right side of the uvula. The most remarkable feature of this curious condition was that

the patient had never suffered the slightest inconvenience from it. Just occasionally she had felt a "lump in the throat" when she had taken cold. Though the tumor encroached upon the lumen of the pharynx, there was no interference with swallowing. The patient was apparently unaware of the fact that she possessed this angioma, and the only history to be obtained was that the soft (? lymphatic) tumor in the front of the neck was first noticed when she was seven years old.—*Brit. Med. Jour.*, June 11, 1887.

DISEASES OF THE EYE.

ABSTRACTS AND SELECTIONS, BY
A. T. MUZZY, M.D.

Sym (W. G.) A Case of Spontaneous Displacement of the Lachrymal Gland.—In May, 1887, a man aged 63 presented himself suffering from ptosis, and a tumor situated in the right upper eyelid. The tumor extended along the whole length of the lid. By its weight it caused ptosis, the eyelids being nearly closed. The skin over the tumor, though slightly congested, was not œdematous, and freely movable over it. The tumor felt firm and lobulated, and was not attached to the deeper structures except about the middle for the third of an inch to the orbital ridge of the frontal bone. It could not be reduced. The ocular movements were in no way affected, and vision was equally good in both eyes. The neighboring lymphatic glands were not enlarged, and the patient was in perfect health. The history was that last January he first noticed the swelling as large as a bean, same characteristics as at present. He also noticed that the right eye was more watery than its fellow, and that the tumor was larger in the morning. Size has steadily increased to the present time. In the winter of 1885, a similar swelling appeared at the same place. This was much smaller, caused no annoyance, and after a few weeks spontaneously disappeared. In a few days after his appearance, a longitudinal incision was made over the tumor. It was found immediately beneath the skin and turned out. An accessory portion was found occupying the normal position. This was left to carry on the function of the gland. With healing from the operation the ptosis diminished.—*Edin. Med. Jour.*, July, 1887.

Tangeman (C. W.) A Foreign Body in the Eye for Seven years and then Removed.—A healthy machinist, 35 years old, applied for relief from pain which had suddenly attacked the right eye the night before. The eye was red, sensitive to touch; with reduced tension and vision (counting fingers at 5 feet). There was considerable photophobia; the pupil was contracted with a few points of posterior synechia, evidently due to a previous inflammation. Exactly in the centre of the cornea was a crucial cicatrix. The patient gave the following history: "In 1876, while at the Centennial Exhibition while using a hammer and chisel I suddenly felt something strike my eye; the sensation was sharp and piercing, and sight was instantly obliterated. An oculist examined it immediately afterwards but could not see any foreign body, and recommended enucleation. This was refused. At the end of four months the condition quieted; I returned to my work, being able to count fingers at two feet." On making examination I found the lens had been absorbed, the iris was tremulous, and the vitreous had become liquid and disorganized. Iris responded somewhat to atropine yet was too contracted to permit a satisfactory examination of the fundus. The anterior chamber was quite shallow, and at the most dependent part was a foreign body. When the patient's head was moved this object moved correspondingly. In the sunlight it was distinctly seen to be metallic. An incision was made with a spear-shaped knife, and after some difficulty from the roundish shape it was removed. It was as large as a small bird shot and slightly corroded. The eye made a good recovery, its vision not diminishing. This was four years ago and no further trouble has been experienced. It would be interesting to know, after piercing the centre of the cornea and dislocating the lens, falling out of sight into the vitreous chamber, how the foreign body should re-enter the anterior chamber?—*Cincinnati Lan.-Clin.*, July 2, 1887.

Jackson (Edward). When and How to Use Mydriatics.—This class of drugs has, besides a therapeutic value, a wide use in the diagnosis of eye conditions. And before using, a clear knowledge of their contra-indications should always be gained. First among these contra-indications comes incipient or latent glaucoma, the eye being apparently normal.

Glaucoma always tends towards functional destruction of the eye, which is many times not controlled even by the most radical surgical means. It must always cause regret to have caused an acute manifestation of such a disease. And it has been well proven that every mydriatic in use has been the cause of such a disaster, save *perhaps* cocaine. A second contra-indication to the use of a mydriatic is its interference with vision. The importance of this should be weighed with other circumstances in every case. Still another contra-indication is a perforating ulcer of the cornea at or near its periphery, when myotics will often render better service. Diagnostically, a mydriatic is employed to show the condition of the iris, or the structures back of it; and to paralyze accommodation. To dilate the pupil requires much less than to paralyze the accommodation in normal eyes. For dilatation a single drop of the following solutions can be used:

Cocaine hydrochlorate, 1 to 25.
 Homatropine hydrobromate, 1 to 500.
 Atropine sulphate, 1 to 2,500.
 Duboisine sulphate, 1 to 5,000.

Daturine, hyoscyamine, or hyoscyne salts of the same strength as duboisine. Of these homatropine gives the more rigid pupil, and its effects pass off in twenty to fifty hours. Cocaine, however, is the most generally valuable dilator of the pupil. Its action lasts from ten to twenty hours; is never so great in strong as in feeble light, giving in consequence less annoyance; it produces proportionately the smallest impairment of accommodation, interfering least with near vision; and its influence can be promptly overcome by the use of eserine; making it especially valuable in those cases where from age or symptoms glaucoma is possible. Another advantage, in spite of the ease with which myotics overcome it and its weak control over accommodation, it produces a wider dilatation of the pupil than any other mydriatic, and this especially in old people. Complete paralysis of the ciliary muscle is hardest to attain in children. To obtain it two to five instillations of a drop of the following solutions are required:

Homatropine hydrobromate, 1 to 50.
 Atropine sulphate, 1 to 120.
 Duboisine sulphate, 1 to 240.

Daturine, hyoscyamine, and hyoscyne in the same strength as duboisine. Homa-

tropine should be instilled at intervals of five to fifteen minutes. The others at longer intervals, to avoid constitutional effects. Cocaine in any strength does not completely control accommodation. For diagnostic purposes homatropine is greatly to be preferred. It reduces to a minimum the period of disability of the eye for work, its action lasting thirty-six to forty-eight hours, against five or six days under duboisine, and ten to fourteen days under atropine. Yet it does usually influence the action of the heart. When paralysis of accommodation is used as a therapeutic measure, such paralysis should *always* be complete. And here atropine and duboisine are preferable. To maintain a dilated pupil against a congested or inflamed iris, or to break up adhesions, use the very strongest mydriatic solutions. Here the maximum effect is desired upon the iris; the intervals of installation should be short, therefore, as every half hour, until full dilatation has been obtained or constitutional toxic symptoms appear. To prevent absorption by the general system the puncta should be everted or firmly pressed against the nasal process of the superior maxilla.—*Polyclinic*, July, 1887.

Colburn (J. E.) The Galvanic Current in the Treatment of Certain Forms of Cataract.

Neffel has reported two cases of undoubted commencing cataract, in which all symptoms of its presence were relieved by methodical galvanic treatment, visual power being completely restored. Erb, in his handbook, says, cataracts have recently been drawn into the field of electro-therapeutics. In 1879, before the use of electricity as a remedy in cataract was known to me, I had the following case: A lady, fifty-three years, consulted me for general debility, loss of vision, and catarrhal conjunctivitis. Had been in poor health for past seven years; no evidence of organic disease of any of the viscera. Family history good, save an aunt and a brother suffering from cataracts. Right eye has been out of use for some time; left eye has grown dim rapidly in two months. Examination showed cataract with vision Snellen No. 8 at 12 inches for right eye, and Snellen No. 5 at 12 inches for left, with correcting glass; under central galvanization the general tone of the patient improved, and some months afterwards, while attending another member in the same family, I found her

reading small print. An examination at this time showed an absorption of the major part of the cataract of the right eye. Since the authorities mentioned at the beginning of this article came to my notice I have treated a number of cases of cataract with central galvanization. These I shall divide according to results obtained into four groups. Group I. includes those in which there was no improvement; this numbers three cases, and their general characters are cataract peripheral; no nebulæ, save in third case, where there were considerable; no change in vision noted for some time before treatment was commenced. Group II. includes cases that have been under observation from four to seven years, in which the improvement has been permanent; this comprises six cases, with the following characteristics in all: the cataract peripheral, with dense nebulæ, diminution of the sight rapid for a number of months preceding treatment, except in number four. Group III. includes cases in which there has been complete removal of short lines and nebulæ; here are three cases, having both lines and nebulæ, vision only partially affected or very little. Group IV., recent cases, in which there has been complete absorption of opacities; both lines and nebulæ found in both cases reported, but vision only partially affected.

At first no distinction was made in the slowness or rapidity of development of the cataract, but it was very soon found that the improvement did not take place in the already degenerated structure, but in that which was changing, viz., the nebular matter about the lines. As to the etiology of cataract or of opacities of the lens, it is evident it can only come from disturbance of nutrition. In thirty-one cases from private work and twenty-six from dispensary practice there was found in ninety per cent of them a history of acute disease or an acute exacerbation of a chronic disease, or an exhausting mental depression preceding the disturbance of vision. In thirty per cent. there was choroidal, retinal or neural disturbance as well.

Frequent sances are not required in a large majority of cases; experience leads one to associate improvement with the visible local changes. In all cases in which the disease is progressive, indicated by fat granules and nebulæ, where electricity is well borne, where choroid and retina are

not greatly degenerated, and where there are no complications of organic kidney, liver, heart, or lung disease, and diabetes, improvement may be expected. Cases in which improvement is not to be expected are those in which vision has remained stationary for some time, and where there are structural changes in choroid or retina. The battery to be used should consist of a number of medium-sized cells giving a steady, constant current. The electrodes should be moistened, the negative placed over the eye, the positive at the nape of the neck or angle of the jaw or elsewhere. Three or four cells should then be turned into the circuit, followed by three or four more until a slight vertigo is experienced, then gradually reducing the number of cells, the whole sitting occupying five to ten minutes.

At first daily sances may be given, decreasing to once or twice a week. In some a very mild current must be used, in others as many as eighteen cells, and in a few a prefatory use of the induced current has to be employed.—*Jour. Am. Med. Ass'n*, June 1887.

Coppez (M.) on Purulent Diphtheritic Conjunctivitis.—In a severe case of purulent conjunctivitis of diphtheritic nature in a babe seventeen days old, the best results were obtained by the use of the juice of a lemon. The corneæ were implicated before treatment was commenced. The resorption of the fibrinous exudation without suppuration of the conjunctiva or a bad cicatrix. In three weeks the child was radically healed, and did not present the least opacity of the cornea.—*Pres. Médicale Belge*, July 3, 1887.

Gayet on Ocular Asepsis.—The author draws the following important conclusions:

First.—That microbes are found under the lids of almost all persons; and that they do not differ much from those found elsewhere.

Second.—That antiseptic methods, or asepsis, appear to exercise only a very slight influence upon the presence of germs in the conjunctival sac, or at least however carefully they are employed it is never certain that the germs are banished from the field of operation.

Third.—That these germs are of various kinds, among which are cocci.

Fourth.—That these germs are not pathogenic is seen by the fact that sup-

puration follows operation in only $6\frac{1}{2}\%$ of the cases.

Fifth.—The cocci seem to include dangerous species which are found in the secretions of eyes in which phlegmonous inflammations have sprung up.

Sixth.—The cocci are not necessarily dangerous, as the author has isolated and cultivated such which have been incapable of exciting even suppuration.—*Lyon Méd.*, July 17, 1887. R. W. A.

ORTHOPÆDIC SURGERY.

ABSTRACTS AND SELECTIONS BY JOHN RID-
LEON, M.D.

Sayre (L. A.) on Rotary Lateral Curvature of the Spine.—Rotary lateral curvature of the spine is distinct from spondylitis, as being a curvature of the spine due to unequal action of the muscles of the two sides of the body, and not to any disease of the bone itself.

The rotation, however, which takes place in this deformity is the most important part of the difficulty. You will observe that the ribs, bending at their angles, rest against the transverse processes of the vertebræ. The head of the rib, an inch or an inch and a half from this angle, rests against the bodies of the vertebræ, slightly sloping upward. We thus have the ribs at their angles resting against the transverse processes of the vertebræ like a fulcrum, the short arm running to the head of the rib against the bodies of the vertebræ, and the long arm being the body of the rib. The power which moves this lever is the serratus magnus muscle, which is inserted into the long arm. Now when the trapezius and rhomboidei of one side contract and draw the scapula backward toward the spine, they thus make tense the serratus magnus muscle on that side, and give it full power to act upon the rib, and by this leverage rotate the spine upon itself.

One of the first things which will be observed is that the lower angle of one scapula is slightly projecting, and this occurs in a very early stage of the deformity; the pelvis also becomes oblique, and you will find one hip more prominent than the other; and by drawing a line from the umbilicus to each nipple there will be found a difference frequently of from one quarter to one half an inch.

The treatment must be governed by the cause which has produced the deformity, and by the condition of the patient when brought under notice. The length of the legs must be equalized. For muscular debility, proper training, gymnastics, massage, etc. The exercises advised by Mr. Bernard Roth, of London, are recommended. Partial self-suspension will also be found a most valuable means of correcting the deformity, if the principle be properly managed. This is effected by the patient having a leather collar passing under the chin and occiput, two straps passing from this up on either side of the head to an iron cross-bar, secured by means of a rope and pulley to a hook or beam in the ceiling. The patient is expected to raise the arms over the head to their fullest extent, and, seizing the rope with the hands, commence climbing up hand over hand until the heels are gradually raised from the floor; the toes, however, should never leave the ground. While holding herself in this position, the patient should take three full inspirations, then slowly descend, until she once more rests firmly on the floor, allowing the arms to fall by the sides and to rest them a few moments; the same course is to be repeated—in all three times. The plaster-of-Paris jacket made in form of a corset and applied when the body is in the improved position which self-suspension gives is preferred to all other forms of apparatus.—*Med. Register*, May 14, 1887.

Stillman (C. F.) on Some New Features in the Mechanical Treatment of Rotary Lateral Curvature of the Spine.—The reduction of the deformity by traction should be effected before any other measures are adopted. Traction for the relief of rotary lateral curvature may be directed in either of four directions,—(1) *horizontal*, (2) *vertical*, (3) *oblique*, or (4) *curved*. In place of the simple horizontal, the oblique is believed to be more effectual. It is obtained by placing the patient upon a table in the sitting position, the buttocks being at a distance from the edge corresponding to their distance from the convexity of the dorsal deformity. The patient then gradually *reclines backward, twisting* at the same time in a direction *opposite* to the twist of the curvature, until the spine is dragged upon by the weight of the head and upper extremities. In addition to the *traction*, which from the position as-

sumed by the patient is exerted in an obliquely backward direction, we have *pressure* exerted upon the prominent scapula and ribs by the edge of the table.

In place of simple vertical traction, suspension on a curved board is advised, or *curved traction*, and while thus suspended, either wholly or partially, the patient takes arm exercises by means of weights and pulleys with which the apparatus is provided.

If suspension is followed by the resumption of the abnormal curves, *brace-treatment* becomes a positive necessity, and may be either *passive* or *active*. The *plaster-jacket* of Sayre is condemned as being a *passive brace*, and not actively effective even in this capacity, owing to the fact that it embraces only part of the spine. An *active brace* is advised, and an extended description of a new one involving the V-lever principle is given with illustrations.—*N. Y. Med. Record*, May 21, 1887.

Shaffer (N. M.) on the Use of Traction in the Treatment of Club-Foot.

—There is only one centre of antero-posterior rotation. It is not at the ankle joint, but considerably below it, and in all our efforts to change a position of permanent extension, due to muscular or fibrous resistance, to that of flexion, we ought to construct the apparatus devised for this purpose with this definitely located centre of motion properly placed. Indeed, it is well to exaggerate the force applied by placing this joint of the mechanism lower down than the normal centre of motion at the ankle joint. In carrying the foot from extension into flexion the heel rotates around the centre of motion and goes *downward* and *forward*, the toes go *upward* and *forward* till the right-angled position is reached, and then *upward* and *backward*, and the neck of the astragalus rotates *upward* and *backward*.

It becomes plain, therefore, that the neck of the astragalus, being tied down, as in the conventional form of apparatus, cannot rotate *upward*, and, if this movement is blocked, the heel cannot go *downward*. To fulfil the above indications the antero-posterior traction apparatus was devised. A careful description of the apparatus and the manner of applying it is given, together with fifteen wood-cuts.

In equino-varus (I speak especially of the congenital type) there is ordinarily no deformity or perceptible deviation from the

normal in the tibia and fibula. The real deformity occurs at and below the ankle joint, the rotation of the astragalus inward, upon a vertical axis (with the ankle in extension), making an apparent outward rotation of the leg and thigh. Under these circumstances, if the leg and thigh are placed in normal position, the malleoli are found in their proper positions. It will then be readily appreciated that the deformity occurs at a point below the inferior articulating surface of the tibia. The really difficult "lateral" deformity is not at the medio-tarsal joint, as so many teach, but is found in the rotation upon an antero-posterior and vertical axis of all the important bones of the tarsus. It will be found that the inner border of the foot is greatly curved. It is also raised, so that the cuboid bone presents in walking. This is due to the rotation upon both an antero-posterior and a *vertical axis* of the whole tarsus. In brief, there are three principal deformities in equino-varus: First, rotation of the ankle upon a transverse axis (extension); secondly, rotation of the os calcis upon an antero-posterior axis (inversion of the os calcis); and, thirdly, rotation of the tarsus upon both an antero-posterior and a vertical axis, including rotation inward of the astragalus and anterior portion of the tarsus. These three deformities are each met by a specially devised movement in the lateral-traction shoe, a description of which, and its application, is given, together with five wood-cuts.

My method is to apply the exaggerated traction at intervals of one half hour or hour for the period of toleration, be it five seconds or five minutes. During the intermission little or no pressure is used, and the patient walks about with the traction shoe applied. Experience proves that what is gained during these seconds or minutes of exaggerated traction is not lost during the intermission, and a frequent repetition of "intermittent treatment" will be followed, as a rule, by a lengthening of the foot, showing that the plantar tissues are yielding; a visible lengthening of the gastrocnemius muscle soon becomes apparent, and the deformity yields to the traction.

I know of no rule by which any one can determine whether a given case will yield to traction, or whether it will require both tenotomy and traction. It will be a very exceptional case that does not yield to the two combined. My rule is to apply

traction first, and, if it fails after a fair trial, to perform tenotomy also. And I know of no apparatus that answers so good a purpose after tenotomy as these traction-shoes.—*N. Y. Med. Jour.*, March 5 and March 12, 1887.

Kenny (J. B.) on the Immediate Treatment of Talipes.—I am inclined to think that a much larger number than is generally supposed of club-feet could be successfully treated without any cutting operation, were measures taken to reduce the deformity immediately after the birth of the infant. When attending cases of midwifery, before I leave the house, should talipes be present, I make a simple splint from a portion of an old bandbox. The splint is cut circumferentially, and not vertically. In this way greater pliability and toughness are secured, advantage being taken of the grain of the wood. It is about one and a half inches wide, and must be carefully padded. The knee being held flexed and steady, I grasp the instep and make traction outwards in simple varus; outwards, forwards, and upwards in equino-varus. Then I wind the bandbox splint from without inwards twice around the foot, and bring the splint up to the knee on the outside of the leg. A small straight splint of the same material is placed on the inner side of the leg to equalize pressure. The splints are tied together at the foot, middle of the leg, and knee, and the whole covered with a roller bandage from the toes up. This is left on about two weeks, and then merely an ordinary roller bandage. I have recently seen two cases treated thus, one a well-marked example of double equino-varus, now seven years old, and the other an extreme case of double varus, now five years old, in which there is no trace of the deformity.—*Provincial Med. Jour.*, Feb. 1, 1887.

Prouty (I. J.) on Talipes Calcaneus.—A case of double talipes calcaneus, congenital, is reported, in which manipulation at the joint and rubbing of the calf muscles were commenced at birth, with the result of a perfect cure in eight weeks.—*N. Y. Med. Jour.*, Jan. 1, 1887.

Barling (G.) on the Causation and Treatment of Flat-Foot.—Three well-defined groups may be recognized: "the nervous," "the statical and atonic," and "the articular," or, as I prefer to call it, "the rheumatic."

The nervous cases are paralytic, practi-

cally all the result of infantile paralysis, which has involved the muscles of the sole of the foot and the posterior muscles of the leg. If cases of infantile paralysis were properly looked after, hardly any deformity should arise, as it may easily be prevented by opposing the action of the unbalanced muscles by the support of instruments, or even simply by manipulation.

The statical and atonic group owns for its origin faulty adjustment of the weight of the body on the tarsal arch, combined with laxity of the ligamentous tissue and want of healthy muscular tone.

The rheumatic group includes the worst cases of flat-foot. After an attack of acute or sub-acute rheumatism, the patient on going about finds the sole of the foot arches after slight exercise, and that there is tenderness over the astragalo-scapoid joint; then flattening is noticed, pronation of the anterior part of the foot follows, and in some instances, instead of a concavity at the inner side of the sole, there is a convexity produced by the prominence of the astragalus and the hypertrophied tubercle of the scaphoid.

In simple flat-foot the treatment is a boot with a strong waist and the arch supported by a pad, or by a strap passing to a band around the calf.

In rigid flat-foot it is a mistake to provide them with pads without first overcoming the rigidity and restoring the arch. The patient should be placed under an anæsthetic, and taking the foot with both hands, with the thumbs pressed firmly against the underside of the astragalo-scapoid joint, the fingers grasping the dorsum, use sufficient force to reproduce the concavity naturally existing in the sole of the foot.

Having restored the arch of the foot, it should at once be fixed by plaster-of-Paris in a position of extreme supination and flexion, and no weight should be placed upon the foot for six weeks or longer. When the plaster is removed, boots provided with proper pads should be applied, and over fatigue should be avoided.

For those cases where there is hypertrophy of the tubercle of the scaphoid, Ogston's operation is advised.—*Birm. Med. Rev.*, Jan., 1887.

Owen (E.) on Psoas Abscess—When and How to Evacuate It.—One of the points upon which I would specially ask for an expression of opinion,

is whether psoas abscess does often undergo spontaneous cure. In my own experience the happy contingency has been so rare that I do not consider it within the range of practical therapeutics. In many years of out-patient practice at a general and a children's hospital, I have met with only one case. My invariable experience—with that one exception—is that when in connection with a stiffened spine, an ovoid or fusiform tumor can be detected ascending in the depths of the iliac fossa, it is only a question of time as to when its purulent contents reach the surface. For their removal aspiration is of no real value. The tubular needle is quickly choked, and flakes of fibrin, shreds of ruined intervertebral discs, and frequently sequestra of the vertebræ can never be removed by it. The abscess quickly fills again, and within a few days of making the attempt seropurulent fluid leaks through the puncture, and unless thorough evacuation be at once performed, the abscess runs great risk of becoming septic. Irresolute attack of any other kind gives equally unsatisfactory result. All this being admitted, there is no alternative for the practical surgeon but freely to open and drain the abscess.

The second point is, when should this thorough evacuation be resorted to? My contention is that the abscess should be attacked as soon as treatment has brought the patient into the best possible condition for the ordeal. There should be no useless temporizing.

The method of evacuating psoas abscess, which I recommend with confidence, is by a free anterior as well as posterior opening, and by then washing and draining the cavity right through. The first opening I make close above the outer end of Poupart's ligament, using the scalpel until about an inch of the length of the fibres of the aponeurosis of the external oblique has been exposed. I then scratch through the fleshy attachment of the internal oblique and transversalis, and, keeping well below the level of the peritoneum, thrust the director into the swelling. Pus escapes, and the opening is enlarged by the dressing forceps and finger. A stiff probe is then passed through the abscess cavity and made to project beneath the skin on the outer side of the erector spinæ. With this as a guide, a counter opening is made in the loin. The large abscess cavity is then flushed perfectly clean with a warm anti-

septic solution, and a drainage-tube, the size of a pen-holder, is laid through the chasm for a few days and the dressing applied.—*Brit. Med. Jour.*, April 23, 1887.

SURGERY.

ABSTRACTS AND SELECTIONS BY GEORGE B. PHELPS, M.D.

Jones (Robert) on the Treatment of Pott's Fracture.—There are two objects to be attained—the reduction of deformity, and the maintenance of reduction.

Reduction is accomplished more readily in proportion to the absence of delay. Walter dressings and Fabian policies should be rigidly discarded, as even twenty-four hours may make a material difference in the easy success of manipulations. My advice to house-surgeons and others is to seize the earliest chance of replacing the astragaloid luxation. A patient brought straight from his fall, with no matter how terrible an eversion, presents no approach to difficulty. It is hard to give any rule of procedure which alike will remedy the defect of symmetry in all cases. Generally speaking, after flexing the knee it is best to firmly grasp the foot, the dorsum in the right hand and the heel in the left, and to steadily pull for a few seconds. Next move the foot a few times from side to side and powerfully invert. Should this fail, start again, repeating the former movements, and on each occasion a gain in the right direction is recorded. This may be even again repeated. If, notwithstanding, deformity yet remains, increase it by still further everting the foot,¹ and then repeat the primary manipulations. Should it still be unsatisfactory, a gradual replacement must be attempted by means of pads. But the effort at reduction should be long continued, and very rarely indeed given up as futile.

[The importance of complete reduction is so great the patient should be, if necessary, anesthetized to thoroughly accomplish it.—P.]

Once reduction be complete there is no tendency to recurrence of deformity, and therefore no real occasion to employ those splints which are devised to counteract

¹ Mr. Thomas has drawn attention to this in the reduction of luxations, *vide* "Contributions to Surgery," part vi.

special displacement. Lest, however, a little deformity remain, it is well to put on a couple of side splints and a posterior splint, the side splints being armed with pads suitably arranged to minimize deformity. The splints I have been accustomed to use are made of malleable sheet-iron, and the practitioner can with his foot press the ends of both side splints, so that they approximate on the sole, forming a support which maintains the ankle at right angles. When the splints are adjusted the patient must be directed to flex the knee and lie on the outer side of the leg. Just a few words respecting the position of the ankle. It is of the utmost importance that the ankle be kept at right angles, and that the bedclothes be prevented from pressing upon the toes and extending the joint. After-results, very serious by reason of their tediousness, are due to neglect of this precaution, and hardly a month passes but a case presents itself at our out-patient department, walking upon his toe with a contracted tendo Achillis, which might have been well months previously, were it not due to the overlooking of this apparently trivial detail. Patients should be kept in splints for fully five weeks, and even then the foot should only be very tenderly dealt with. Mr. H. O. Thomas is accustomed to crook the heel of the boot, the slope being from without inwards, the lowest point being on the inner side, as soon as the time for walking commences, and this precaution will be found of much service. The more moderate the exercise during the initial period of walking, the better the ultimate result. The patient should be kept under observation for at least three months.

Among the troubles following these fractures we may place :—

1. *Persistent Pain over the Ankle-Joint.*—This is generally due to injury which the articular surface has suffered at the time of accident. It must have been sufficiently severe to have outlasted the period of rest which the fracture necessitated. The pain is generally most marked over the deltoid ligament, and though lessened does not disappear at night-time. It is accompanied by fulness over the joint, which may or may not include the rest of the foot. It is needless to say that passive motions in such cases are sad blunders, and result in increased pain and decreased movement. Rest is the remedy.

2. *Swelling of Foot Increased on Move-*

ment.—This may be due to chronic synovitis, but generally results from circulatory disturbances, arising sometimes from the results of tight bandaging, but oftener from inefficient reduction, with subsequent outpourings of callus. The errors in circulation are best attended to by directing the patient to elevate his leg, to keep his knee slightly flexed, to apply hot applications, and to adopt surface frictions from foot to knee twice every day. A little exercise is good, but immediately on return let the patient fall on his back and elevate the foot.

3. *Pain over Site of Fracture.*—As a rule this is due to the unsoundness of the bond of union, and is frequently the result of permitting too early perambulation. It may or may not be accompanied by deformity. The treatment of the former cases I shall at some future date take an opportunity of publishing in detail, with accompanying diagrams. If there is no deformity the ankle should be still further kept quiet, should be supported by plaster, and later on the heel of the boot crooked as suggested by Mr. Thomas. If despite these precautions walking is irksome, an iron stem should be fitted to the outside of the leg, and into the heel of the boot, and the leg well bandaged to it night and morning.

4. *Contracted Tendo Achillis.*—This is a common accident of neglected precaution in the treatment of Pott's fracture. There is no excuse for it. *It should be an axiom that the foot be kept at right angles.* Simple as the treatment of such cases may appear, in actual practice real difficulty is encountered. Suppose, for instance, the case is one where the joint has become stiff from articular mischief. Division of the tendon here would avail but little, and we shall be forced to adopt those measures applicable to ankylosis. In other instances also where there is no arthritis, much force has to be expended upon the foot, in addition to tenotomy, before the result is respectable.

It is therefore clearly wiser to avoid the necessity.

The after-treatment consists in knocking the heel of patient's boot, and directing him to amply exercise the stiff articulation.

5. *Deformity.*—This may be due to inefficient primary reduction, or to return of displacement from pressure on the foot

during unsoundness of the fibular bond of union.— This will be treated of later.

[In this city Pott's fractures are usually put up in a plaster-of-Paris splint.—G. B. P.]
—*Liverpool Med. - Chirurg. Jour.*, July, 1887.

On Reunion of Severed Digits.—In the *Medical Record* of November 13, 1886, a number of cases are collected in which, after the complete severing of a finger, it was replaced, sutured, and united perfectly.

Dr. Charles W. Galloupe¹ reports two cases which terminated successfully. In one, the distal phalanx of the thumb was severed diagonally by an axe, and it fell among some shavings. This fragment, after a few minutes, was picked up, wiped, replaced, and fixed by means of plaster strips. It united, and, with the exception of diminished sense of touch, was as good as before.

The other was amputated in a sole-cutting machine. He also reports two unsuccessful cases.

Dr. O. N. Bradbury² reports the following successful case, which occurred in a boy of seven :

"The axe came down too near the hand, and severed the forefinger of the left hand, just above the second joint. The cut was made square and complete, the severed end falling among the chips, where I found it about twenty-five minutes later. Warmed it fully in warm water ; adjusted it with great care ; took two stitches, strapped, and splinted carefully. Two years afterwards, it puzzled me to tell which forefinger had been cut. The merest trace of a scar was found. The action of the joint was perfect, the finger was well nourished, the muscles apparently as strong as those of the other forefinger, and the little fellow would not acknowledge there was any numbness."

Dr. De Loffre³ reports a very similar case. The patient had severed with an axe about one half inch of the ring finger of the left hand. He applied for treatment without the amputated member, and a messenger was sent to search for it, and after about twenty minutes it was brought to the doctor who carefully washed it in tepid water, replaced it on the stump, secured it by means of strips of plaster, and hermetically sealed the dressing with collodion.

No other dressing was used, and in a

little more than a month the piece had freely reunited. Ultimately, the sensation was entirely restored.

Other similar cases are recorded. Also many cases in which the nearly-severed portion of the finger was connected to the stump by a very narrow strip of skin.

It, then, seems proper when a portion of a finger has been amputated accidentally, and the cut is a clean one, to cleanse the finger, and, with antiseptic precautions, to unite the two parts by two or three sutures, and then apply a permanent supporting dressing.

If the severed portion does not unite, the healing of the stump will have been delayed but little.

On an Unusual Form of Injury to Tendons.—Dr. J. H. McIntyre⁴ describes the following rare cases of injury : A man aged sixty-two caught the ring finger of his left hand in a dough-mixing machine. The finger was torn off at the distal joint, and with it the extensor tendon was brought away, it having ruptured at the muscular attachment at the elbow. "The stump was dressed in the usual manner." Severe inflammation followed, and five abscesses formed along the line of the tendon, and patient recovered with "fair use of hand and arm."

Four days after this patient was discharged, a man aged thirty-two had his right thumb caught in the same machine. It was torn off at the middle of the last phalanx, and with it the tendons of the flexor longus pollicis and extensor secundi internodii pollicis came away, having been ruptured at their muscular attachments. The treatment was like that in the preceding case, and was likewise followed by abscesses in the hand, and were accompanied by considerable constitutional disturbance.

Dr. W. V. Kingsbury⁵ reports the following case. A boy of fifteen had the big toe of his right foot caught in a paper-cutter. The first phalanx was torn away, and with it $1\frac{1}{4}$ inches of the extensor proprius pollicis, and $8\frac{1}{2}$ inches of the flexor longus pollicis. Each was torn at the point of muscular attachment.

Chloroform was given, the edges of the wound was freshened, and after being washed were sutured. An antiseptic dress-

¹ *Boston Med. and Surg. Reporter*, Nov. 25, 1886.

² *Ibid.*, Dec. 16, 1886.

³ *Boston Med. and Surg. Jour.*, Dec. 23, 1886.

⁴ *St. Louis Med. and Surg. Jour.*, July, 1887.

⁵ *Ibid.*, Aug., 1887.

ing was applied, and over this a plaster-of-Paris splint. Primary union was not obtained, and the wound healed by granulation. There was no inflammation or soreness along the tracks of the tendons at any time. The writer was able to find only five similar cases on record, and these were cases in which fingers were torn out.

On the Medico-Legal Significance of Two or More Mortal Wounds.—

An interesting editorial in the *Medical News* for August 27, 1887, of recently reported cases in which a suicide has fired more than one shot in accomplishing his object, concludes as follows :

First. The presence of two or more wounds in a dead body is not inconsistent with the idea of suicide. There is abundant proof to show that a person determined on self-destruction may first shoot himself in the head, and immediately follow it up by a shot through the heart, or *vice versa*.

Secondly. In the case of two bullet-wounds in a suicide, made by a self-cocking pistol, it is quite possible that the second wound may have been inflicted unconsciously and automatically in the descent of the arm after firing the first shot. This, however, could only occur where a self-cocking pistol had been the weapon used ; we do not believe it to be possible with an ordinary pistol.

Thirdly. In an unknown case, and in the absence of all evidence, the presence of several wounds upon a dead body would generally be suggestive of murder ; although, as we have seen, it might not be positive proof of it. The nature of the wounds, their position and direction, are the important circumstances which would here have to be considered.

Gibney, (V. P.) on Dissecting Aneurism about the Hip Dependent upon the Rupture of the Internal Pudic Artery.—The patient was a boy fifteen years of age, seen first March 21, 1887. In the summer of 1886, it was discovered that he had a double valvular disease of the heart, probably congenital. During that season he fell from a bicycle, but the fall was not followed by lameness or pain.

March 1st, of this year, without any provocation began to walk stiffly, favoring right limb. Seven days later struck on the right hip with the fist of a playfellow. This was at once followed by pain which increased, and remained throughout the course of the disease. A diagnosis of rheumatism was

at first made, but a large fluctuating swelling soon appeared over the right hip, and when seen by Dr. Gibney, March 24th, it extended from the crests of the ileum on the right side to the middle third of thigh. Temperature varied from 100° to 102°.

The appearance of the tumor, the absence of pulsation or bruit, pain on movement of the hip, and the temperature curve, induced him to regard this as a case of acute subfascial abscess, or what might be termed an acute suppurative peri-arthritis.

On several occasions long hypodermic needles were passed into the tumor, and withdrew blood. The blood globules were not degenerated.

On April 3d, Dr. Keyes, having been called in consultation two days' before, made an incision into the tumor. A gush of blood followed. The incision filled with clots ; ether was then carefully given by Dr. Lee, a crucial incision made, the clots turned out, and the internal pudic artery found bleeding in the bottom of the wound. The bleeding points were promptly seized with the clamps, and as the patient's condition was very poor, no attempt was made to apply a ligature. The wound was packed with absorbent cotton.

The patient rallied well and talked freely, but again sank and died nine hours after the operation. There had been no further bleeding.

Dr. Gibney says :

"It will be seen, then, that this was no ordinary case. The record of the temperature shows a regular curve over which it ranges from 99½° to 104°. The etiology is exceedingly obscure. Whether the vessel was injured at the time of the blow on the hip, on March 7th, is somewhat doubtful ; and yet, if the statement of the family and of the boy himself can be admitted in evidence, this certainly seems to have been the beginning of his tumor. Why he should begin to limp on March 1st and continue limping until the 7th, the day of the injury, is difficult to understand. The explanation seems to my mind this : The mere attack of subacute rheumatism would account for the lameness, and the blow of the playfellow might rupture the artery, as it lies very near to the bone at this point. The boy's muscle and adipose were not abundant in this locality.

"It was difficult for me, as well as for the other gentlemen in the case, to regard this as any thing more than a subfascial abscess,

and even after the exploratory puncture it was difficult to reach the conclusion that finally pressed itself upon us. As Dr. Lee states, and as Dr. Keyes states, the whole course was unlike that of dissecting aneurism. I had no difficulty in excluding ostitis of the hip, or synovitis even, when I first saw the case. The signs, the symptoms, all pointed to a periarticular lesion."—*Med. Record*, Aug. 27, 1887.

Hunter. (R. H. G.) on Painless Destruction of Nævi.—A. B., aged two, suffering from a nævus, the size of a shilling, behind the right ear, was on May 12, 1887, treated by me in the following manner for its removal. Having first painted the healthy skin around the circumference of the nævus, for about half an inch, with a coating of collodion flexile, I applied a thick layer of a 4 per cent. solution of corrosive sublimate in collodion over the nævus. On the 25th, when I removed the collodion, the nævus had entirely disappeared, and nothing remained but a small scab. Dr. Böing was the first to suggest this method of treatment, and my object in publishing this case is to draw attention to so simple, satisfactory, and painless a method of treatment.—*Brit. Med. Jour.*, June 11, 1887.

Reliquet on the Treatment of Cystitis.—1st. Take morning and night a large enema of tepid water.

2d. An hour after having taken the enema, introduce deeply into the rectum the following suppository :

- B Extract of gelsemium, gr. i.,
Iodoform, gr. i ½,
Cacao butter, gr. xlv.

3d. In case of a urethral discharge, take morning and night a pill of terpine, gr. i ⅔.
La Thérap. Contemp., July 29, 1887.

R. W. A.

Padiou on the Consolidation of Fracture after the Termination of Pregnancy.—The subject broke both bones of the leg Jan. 4, 1886. The fracture was simple and without much displacement. At the end of three and a half months the patient was put on crutches to expedite union, the callus still remaining soft and flexible. A possible pregnancy then suggested itself. On questioning it was found that the menses had last appeared nine days before the accident. Examination revealed a pregnant condition, which terminated normally. Ten days after confinement, the hitherto soft

callus began to harden, and consolidation was complete at the expiration of a month.

The incompatibility of speedy union of fractures and pregnancy has already been noticed by Dupuy, *Jour. de Méd. de Bordeaux*, 1853.—From *Gaz. Méd. de Picardie* in the *Jour. de Méd. et de Chir. Prat.*, July, 1887.

R. W. A.

Ady (A.) on Plugging the Nostrils.—The plan I have followed for many years is to take the cæcum of a chicken, turn it inside out, and scrape the mucous and muscular coats away, leaving the peritoneum. This makes a sack that when passed through the nostrils and distended with water and tied in front, makes a very efficient plug—large enough to evenly fill the nostril, preventing hemorrhage very effectually. It does not irritate nor stick fast, and is very easily removed by snipping off the outer end, allowing the water to escape, when the gut is very easily withdrawn. I do not claim this as original.

When a chicken is not handy, I have used a gum condom in the same way ; and the smaller one of a set of Barnes' bags has answered the purpose very well in a large nostril.—*Med. and Surg. Reporter*, July 30, 1887.

R. W. A.

Stewart (G.) on Bronchiectasis Cured by Excision of Ribs and Drainage.—A young man, aged 27, for nine years had suffered from an offensive bronchorrhœa. The discharge was so offensive that his life was intolerable. The condition had been diagnosed as due to bronchiectasis, and the usual remedies exhibited without success. When the patient was received into the Royal Infirmary the smell was so offensive that he had to be placed in a private ward. After consultation, Professor Stewart came to the conclusion that the case was one of bronchiectasis. All the circumstances of the case seemed to indicate the adoption of operative treatment. Mr. Caird inserted an aspirator-needle, which gave exit to a thick, purulent fluid. He then made an incision, resected two ribs, and established free drainage. The immediate result was that temperature fell, there was a total disappearance of the offensive odor, and the patient's general condition and appearance improved much. The case had gone on continuously well. The drainage-tube was still *in situ*, but the amount of discharge was less, and it was not offensive. Curiously enough, the patient's mental condi-

tion, which prior to the operation was below normal, had improved considerably.—*Brit. Med. Jour.*, July 23, 1887. R.W.A.

Link (J. E.) on the Physiological Treatment of Wounds.—In illustration of the principles which should underlie the treatment of abdominal wounds may be cited two cases of gunshot wound of the abdomen in which no surgical interference was had. The first was a small boy who in carelessly handling a pistol received a shot near the umbilicus. He was thoroughly narcotized with opium and whisky, and the knees well up to the body with the head and shoulders well forward. The child recovered.

The second case was that of a man who received a shot just below the umbilicus with a 32-ball. He was kept with the body well flexed to the front and completely narcotized with opium and whisky for ten days, at the end of which time fluid food was administered. No effort was made to probe the wound or diagnose its location. The case completely recovered.

The third case was of a boy who carelessly shot himself by exploding a railroad torpedo. Laparotomy was performed. The first wound was found to be a clip through the side of the ileum and on through the mesentery at its attachment to the gut. The hemorrhage was excessive. A second wound was found on the convex side of the gut, passing through, leaving a small portion of the intestine between on the side of the superior curvature. The third wound was through the gut, clipping it so as to make it a single hole large enough to admit the index finger at the lesser curvature of the mesenteric attachment. The missile consisted of a fragment of the shell weighing two grains, and was found imbedded in the mesentery. After the operation large doses of whisky and paregoric were administered, and the boy made a complete recovery.

These cases are cited with a view of substantiating the following principles: 1. An abdominal wound should not be probed unless with a grooved director as a guide to the scalpel. 2. Many wounds of the cavity and of the viscera may recover with fixation, narcotization, and abstinence from food. 3. The cavity is susceptible of invasion by the surgeon in recent injuries as well as for other conditions.—*The Med. Standard*, Aug., 1887. R. W. A.

Belfield (W. T.) on Transplantation of an Undescended Testicle.—The patient was a healthy youth 20 years

of age; in his thirteenth year a small lump appeared in the right groin; during several years thereafter it increased in size, and frequently occasioned severe pain, especially during active movement. Two physicians consulted during that time, pronounced the swelling hernia, and advised trusses; but these failed to relieve, the patient being frequently unable to work or walk for several hours.

The tumor was found, on examination, to be a fairly-developed testicle, lying upon the middle of Poupart's ligament, just exterior to the external inguinal ring; no hernia. The right side of scrotum was undeveloped. The coverings of the testicle were exposed, the organ and its cord loosened by dissection, and the testicle pushed downward into the scrotum and stitched to the bottom thereof. Dressings were so applied as to prevent retraction by the short cord. The stitches, however, pulled out. After healing, the testicle was found, freely movable in its tunic, at the upper portion of the scrotum, just below the pubic arch. The patient attends to his duties with perfect freedom from pain and discomfort. This appears to have been one of those unusual cases in which a testicle, retained in the inguinal canal until puberty, resumes at that period interrupted descent. Such tumors may easily be mistaken—as was this one—for hernia.—*Med. Age*, Aug. 16, 1887. R. W. A.

Cross (L.) on Spontaneous Cure of Hydrocele of the Cord.—Mr. D. consulted me in reference to an old hydrocele which had suddenly disappeared.

He had been the possessor of this hydrocele for several years, and it had been his constant companion, save on two or three occasions, when it had been tapped and its contents withdrawn. The last tapping it received was on the 5th of November, 1885, when he was operated on for radical cure by the injection of pure carbolic acid. The operation was a failure, because it was improperly or imperfectly performed, for want of proper assistance.

On the evening of the 12th of February, 1887, he retired in the usual good health, slept soundly, and in the morning when he arose and attempted to adjust himself into his pants, discovered for the first time that his old and familiar friend had been stolen from him. He examined his bed and examined his drawers, to find that not one drop had been spilled by the angel visitor.

I found an empty scrotum and an enlarged and indurated left testicle. The rapid absorption was the novel feature to me, as well as surprise, because it could not be traced to any traumatism or exciting cause, not even to the spiritual stimulus of a faith cure.—*Alb. Med. Annals*, April, 1887.

R. W. A.

MISCELLANEOUS.

Collinet on Spontaneous Delivery in a Case of Contracted Pelvis three Inches in Diameter.—This case was of much interest for the following reasons: 1. Because it seemed simply retarded by the contracted pelvis and an uncorrected occipito-posterior position. 2. Because of the successful termination of labor, both to mother and child; as, according to Charpentier, in eleven confinements where the pelvis was as small as in this case, there was a fatal issue for the child in five cases, for the mother in one case. 3. Because of the spontaneous expulsion of the child with the occiput posterior without internal rotation.—*Jour. des Sci. Méd. de Lille*, July 15, 1881.

Moure (E. J.) on Hard Chancre of the Right Nasal Fossa.—The patient, a man of 54, consulted the author for a difficulty of breathing in the right nostril. He also suffered severe pain in that side of the face below the orbit. The voice was nasal, and the nose red and tender. There was a slight ichorous discharge from the nostril. It had an odor, but was not foetid. His trouble commenced six or seven months previous by a slight itching of the nose. He denied having had any venereal disease, except a clap a long time since. On examination, besides the redness, the right ala of the nose was seen to bulge from the presence of a grayish-red fungous growth in the right nostril, which had its origin on the septum, a centimetre from its anterior border. The tumor was covered with mucus, and bled easily.

The left nasal fossa was intact, and there was no deviation of the septum. The buccal and pharyngeal mucous membrane was normal. The right submaxillary ganglia were enlarged, but not tender.

The patient was put upon mixed treatment, with local injections of a solution of resorcin.

Eight days later—two months after the first nasal symptom—the patient reported

to the doctor with an indubitable roseola and other secondary symptoms: headache, general malaise, and mucous patches in the throat.—*Rev. Mens. de Laryng., a' Otol., et de Rhinologie*, July 1, 1887.

Guthrie (A.) on Poisoning by Poke Root.—On the evening of March 25, 1887, I was called in haste to see J. H., a stout muscular colored man, thirty-nine years of age, who was said to have been suddenly attacked with "vomiting and cramps in his bowels." I obtained the following history from him: In the afternoon an old vender of domestic medicines was in the city, with, among other things, a large quantity of poke root, which he said was good, when put in whisky, to purify the blood. My patient asked him if it was not good to chew also, and upon receiving an affirmative answer, placed a small piece—probably 3 j or 3 ij—in his mouth and began to chew it and swallow the juice. This was about 3.30 P.M. About one hour later, being thirsty, he drank a pint of cold water, and shortly afterwards nausea set in, soon followed by vomiting, at first of the contents of the stomach and then of a greenish-colored and very bitter fluid. He continued to vomit frequently till 7 P.M., when he began to have severe pain in his bowels, accompanied by free purgation and hæmatemesis.

When I first saw him, at 7.30 P.M., he complained of heaviness in the head and dizziness, was suffering severely from pain in the abdomen, and said he felt as though there was a hard lump in his stomach. He was considerably prostrated and sweating freely; pulse 90, soft and compressible. At 8 P.M., I gave him subnit. bismuth., gr. x., morph. sulph., gr. $\frac{1}{2}$, and ordered it to be repeated in half an hour if he obtained no relief, and also to have hot, dry woollen cloths applied to his abdomen, and allay his thirst with mucilaginous drinks. At 9 P.M. I saw him again. He was a little easier, but had vomited three times in the interim, and each time a considerable quantity of blood. I now gave him morph. sulph., gr. $\frac{1}{4}$, dissolved in a little cold water, after which the pain soon subsided. He vomited twice during the succeeding hour, then fell asleep and awoke the next morning comparatively well.—*Four. Am. Med. Ass'n*, July 23, 1887.

Bradley (C. C.) on a Case of Aconite Poisoning, with Recovery.—A patient, age not stated, swallowed an ounce

and a half of Fleming's tincture of aconite. After the usual symptoms of numbness and tingling of the lips and extremities, profuse sweating, cold surface, and dilated pupils, general convulsions occurred. These were three in number and epileptiform in character. Three hours after taking the dose the patient became comatose, pulseless, and devoid of sensation, respiration became stertorous and irregular, and the heart-sounds almost imperceptible. After remaining in this condition for nine hours, the circulation was gradually restored. Treatment consisted in administration of emetics, followed by brandy, ether, digitalis, ammonia carbonate, and caffeine, hypodermically and per orem, ammonia and amyl nitrite by inhalation, and hot applications externally.—*N. Y. Med. Record*, Aug. 6, 1887.

A New Uvulotome.—Dr. Greville MacDonald, in common with many others, having found that, in attempting to follow Bosworth's plan of excision of the uvula, the mucous membrane sometimes retracts and exposes a sensitive muscular stump, has devised a new instrument for this simple operation. Essentially it is a pair of strong curved scissors, with a pair of forceps-blades lying beneath and almost in contact. The latter, while the scissors are still wide open, grasp the uvula. The projecting arm at the end of one blade prevents the uvula from slipping back during cutting. With the mouth wide open and the tongue depressed, the patient is instructed to breathe in and out gently through his nose, whereby the velum is relaxed and the uvula brought into a vertical position. This is the more easily effected, since an elongated uvula is generally accompanied by a semi-paretic condition of the soft palate, both being probably dependent upon a chronic congestion of muscular tissue as well as mucous membrane. The instrument is then opened wide, and that portion of the uvula which it is desirable to remove is carefully included in the forceps-blades and rapidly cut through. If the operation has been efficiently performed, we should be unable to see the cut surface. It is scarcely necessary to add that no more than the redundant mucous membrane should be removed.—*London Lancet*, May 7, 1887.

Kemp (G. H.) on a Means of Facilitating Catheterization in Women.—In a primipara, aged 26, the vagina,

urethra, and neighboring parts became much swollen and very irritable after a rather severe labor—in fact, so much so that it was found impossible to introduce the catheter. While reflecting on what to do next, it occurred to me to use cocaine. A small compress was saturated with a four per cent. solution and applied to the irritable parts. In the course of half an hour another attempt was made to introduce the catheter, which proved successful. The effect of the cocaine in allaying the tenderness and pain was so decided that the patient complained scarcely at all while the instrument was being used.—*N. Y. Med. Record*, July 30, 1887.

BOOK NOTICE.

Treatment of Hemorrhoids by Injections of Carbolic Acid.—By Silas T. Yount, M.D., Physician of St. Elizabeth's Hospital, etc., La Fayette, Indiana. The Echo Music Co., La Fayette.

This "little monograph" gives a brief sketch of the pathology, and describes the various kinds, of hemorrhoids. It contains some common-sense remarks about rectal examinations, and details the method of treating hemorrhoids by the injection of carbolic acid. This the writer uses dissolved in water, employing, ordinarily, a three- or five-per cent. solution.

A number of cases are reported in full, among them two or three in which accidents delayed a prompt recovery.

This book, though brief, rough in style, and containing very many typographical errors, is evidently written by one who has actually treated rectal diseases.

G. B. P.

PUBLISHERS' NOTES.

"Bromidia."—The United States Circuit Court has granted a perpetual injunction restraining Byron Fenner from the publication of a formula for a liquid medical preparation the name "bromida," unless there is also published, in connection with the said words, "bromida," or "bromidia," a statement that the preparation covered by the said receipt is put up and sold by Battle & Co., of St. Louis, under the trade-mark of "Bromidia." The court has also granted a perpetual injunction restraining D. W. Gross & Son "from manufacturing, selling, or offering for sale, directly or indirectly, any medical preparation having affixed thereupon the word 'bromidia' without obtaining the consent and

duly crediting the same to Battle & Co. as the exclusive manufacturers thereof."

Chronic Uterine Inflammation.—

Mrs. W. H. consulted me. On examination she was found to be suffering from chronic uterine inflammation, elongation and ulceration of the os uteri, with anteversion, and the usual concomitant symptoms, such as frequent desire to micturate, inability to walk, etc. Her womb was easily replaced, but returned to its abnormal position on her attempting to walk. Various kinds of pessaries were attempted, the ulceration having been previously healed by the use of the nitrate of silver and the glycerine plug, but their presence could not be tolerated. The recumbent position was then enforced for a fortnight; during this period her only treatment consisted of mild saline aperients at intervals of two or three days, and the exhibition of Aletris Cordial, in drachm doses three times daily, gradually increased to two drachms. She then began to take gentle exercise, and has steadily improved, and is in expectation of soon becoming a mother. She had never been pregnant previously.

HV. BAYFIELD, *L. R. C. P., Surgeon.*
Somers Villas, Lavender Hill, S. W.

"Lactopeptine."—

CHICAGO, ILL.

No other preparation of Pepsin, in my experience, has such certain and decided effect as *Lactopeptine*.

A. BROOKS, M.D.

"Lactated Food."—

PHILADELPHIA, January 18, 1886.

WELLS & RICHARDSON CO:

Gentlemen—We have been testing your Lactated Food in our Maternity and Nursery Departments, and the results have been so very satisfactory that it is with pleasure that I commend it to the profession.

Very truly,

T. N. McLAUGHLIN, M.D.,
Physician-in-Chief.

"Crystalline Phosphate."—

DETROIT, MICH., Sept. 16, 1886.

Provident Chemical Works, St Louis, Mo.

GENTLEMEN—Your Crystalline Phosphate was received and administered to a patient, whose condition I assumed indicated Phos. The patient did not die, but recovered. I leave you to draw inference.

Yours truly, J. E. CLARK, M.D.

"Murdock's Liquid Food."—

GENTLEMEN—During the past year I have used Murdock's Food a good deal, and it has given me in every case thus far

most excellent results. For anæmia, and in one case of pernicious anæmia, the results following its use were remarkably good. For certain forms of gastric irritability and feeble digestion I invariably recommend it. It has proved especially valuable in those cases of general debility in which tonics and iron prove useless. In short, I think highly of "Murdock" in all those cases in which the nutritive function is radically impaired. Respectfully, WM. J. BANER, M.D.

"Horsford's Acid Phosphate."—

Dr. H. P. ATHERTON, Great Barrington, Mass., says: "I have been using and prescribing your Acid Phosphate for a number of years. The results have been so satisfactory as to justify me in giving it my unqualified endorsement. I have found it a refreshing and exhilarating beverage during summer months. In a case of reformed inebriety, I have observed its restorative effect in toning up the system and correcting the nervous derangement of the subject."

"McArthur's Hypophosphites."—

MCARTHUR'S HYPOPHOSPHITES is made only for physicians. The size of the bottle has been increased from nine to nearly twelve ounces by measure. If you wish to test this valuable compound, they will send a sample bottle free, except express charges, if you mention the ANALECTIC.

"Stammering Cured."—

Dr. E. S. Johnston of Philadelphia, Pa., wishes to call the attention of the medical profession to his system of permanently curing stammering, stuttering, and all nervous affections of speech. His system is endorsed by such eminent physicians as Dr. Lewis A. Sayre of New York City; Dr. H. C. Wood of Philadelphia, Pa., Dr. Marvin and many others. See advertisement on another page, and send for catalogue, mentioning THE MEDICAL ANALECTIC.

"Iron Alum-Mass."—

Send to Dickey & Anderson, Bristol, Tenn., for analysis and treatise of this well-known tonic.

"Medical and Surgical Sanitarium."

—Battle Creek, Mich., is proverbially a healthy city, its annual death-rate being less than that of almost any other city of its size in the country; and the portion of the city in which the above sanitarium is located has always been regarded as the most desirable of any, from a health standpoint. See advertisement and send for catalogue, mentioning the ANALECTIC.

THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

VOL. IV., No. 10.

October, 1887.

WHOLE No. 46.

LEADING ARTICLES.

On the Infectiousness of Croupous Pneumonia.¹—The appearance of pneumonia in a more or less epidemic form, from time to time calls the attention of the profession to its possibly infectious nature; but there is by no means yet an entirely unanimous acceptance of such a view.

By far the most startling recent account of epidemic pneumonia is that reported by Rondet.²

The first epidemic which came to his notice occurred at the village of Fleurieu, near Lyons, and 300 yards from the river Saône. The country is low and fertile, the summers hot, and the other seasons very damp.

The people are farmers, temperate, laborious, and well-to-do. Their water was obtained from wells.

The epidemic started at a cold, damp, wintry, cloudy time, in a house containing a school, the family of the keeper, and the instructors.

The first victim was the principal, a rather intemperate man, of 55, who was seized with pneumonia March 29, 1882, which began to resolve April 10th.

April 9th, a little girl of 8, who attended the school, was seized with pneumonia of the right apex.

April 13th, an elder sister of the preceding came down with pneumonia.

April 14th the grandmother of the two girls developed pneumonia. She had been nursing them. She was 68 years old, in poor health, and succumbed to the disease in five days.

April 21st, the brother of the last patient, a man of sixty, developed pneumonia, which proved fatal in five days.

April 24th, a cousin of the last case was seized and died in 4 days. He, with his cousin, had visited case No. 4 and had spent much time in the children's chamber. He was a man of 42, and had had a pneumonia some months before, from which he had convalesced.

April 24th, a little girl of 9, who attended school where the first case occurred, was seized with pneumonia from which she defervesced in 7 days.

April 30th, a woman of 33, living 100 yards from the first case, was taken down and began to convalesce in a week.

May 1st, a man of 55, living at the other end of the village, sickened with pneumonia and died in five days.

Last of all, an instructress of 40, who lived at the house of the first case, and who had made numerous visits to cases 2, 3, and 4, went safely through an attack of pneumonia.

The mortality of this epidemic was 40 %.

Situated in front of the village of Fleurieu, on the opposite bank of the Saône, is the almshouse of Albigny. Here the second epidemic occurred. It has the same climacteric conditions as the former place, made worse by contracted quarters which allow poor light and ventilation. The inmates are of two classes; poor people, who voluntarily seek admission, and tramps committed by a magistrate; in all, varying in numbers from 630 to 650. During the epidemic of pneumonia it contained 637 inmates, of whom 69, or more than $\frac{1}{10}$ were attacked.

The disease broke out Nov. 10, 1886, and continued until the end of April. During that time the air was cold and damp, and the sky cloudy. Previous to the outbreak there had been no pneumonia in the

¹ See MEDICAL ANALECTIC 1886, pp. 312, 313, 314, 482.

² Relation de Deux Épidémies de Fluxion de Poitrine, etc., par Henri Rondet.—*Lyon Méd.*, May 29 and June 5, 1887.

establishment for a long time. The first victim had been an inmate for a year.

The disease took on in each case the adynamic form, and presented generally all the signs of lobar pneumonia; $\frac{1}{4}$ of the cases having broncho-pneumonia symptoms. The pulmonary lesions were very extensive. The sputum was of a very dark yellow. In some speedily fatal cases it was greenish-brown, almost black. The temperature was very high, always reaching 104° , and sometimes 105° . The skin was very dry; the tongue parched and blackish. Constipation was the rule. The color rapidly became earthy, expectoration difficult, and the patient died in a state of profound adynamia.

Most of the deaths occurred in the first seven days, and many in the first three or four. Convalescence in those that recovered was very tedious.

The average age of inmates was 60 for the men and 55 for the women, and it was between the age of 60 and 70 that most deaths took place.

None of the tramps, male or female, took the disease. They were poorly fed and sheltered, but had more fresh air than the voluntary inmates of the almshouse.

More women died than men (men 24, women 35), and their quarters were on the north side of the building, getting much less sunlight than those of the men.

In the village of Albigny near-by, having the same air and exposure as the almshouse, no cases occurred during the epidemic. At a place called Couzon, a little farther south on the river, three cases occurred. One aged 74 was isolated and recovered; the second case was a woman, who recovered, while her husband, who nursed her, took the disease and died.

The author concludes that pneumonia is infectious, and that under favorable conditions may take an epidemic character.

If the environment is healthy, the chamber well ventilated, lighted and clean, the first case will generally be the last; but if it be old people, catarrhal and debilitated, who contract the disease, an epidemic will be started if their quarters be close and dark.

The diminution of the infectiousness and consequent fatality of pneumonia in the absence of generally considered advantageous surroundings of civilized life, is

known to all. When the air of the sick chamber is cool, it doubtless exerts an antipyretic effect, and free ventilation means attenuation and consequent weakening of the morbid virus, if such there be.

Dr. C. H. Elliott, of Paducah, Ky., says:

"I have seen and treated a great many cases of pneumonia, from five to twenty every winter. I think, of late years, that many if not all the rooms of pneumonia patients are kept too close, not admitting a sufficient amount of fresh air. This conclusion I draw from the fact that I have treated many cases successfully in open log cabins, with nothing but boards nailed over the spaces between the logs, and have known it at night to snow all over the bed on which the patient lay. Under such conditions I have often been quite solicitous as to my patient's welfare; but upon my arrival next morning would find him in no wise the worse. In fact most of my cases for a number of years were in just such houses. I remember to have treated one man for pneumonia for six or seven winters, who lived near the river in an open log house. It is but just to say that his attacks were not of the worst type.

"From these facts which have come under my own observation, I have long since been driven to the conclusion that much of my success was attributable to the free ventilation of the apartments of the sick."

As to the neutralizing effect of sunlight on the supposed infectious material of pneumonia not so much is known, although Arloing, as Rondet says, has proven it destructive to the bacillus of anthrax and its spores.

Dr. A. E. Bell reports¹ a series of cases which help to substantiate the theory of infection. These cases also occurred among well-to-do gardeners living in a neighborhood usually healthy.

The first case was a child of four, who had pneumonia the year before. In a few hours a brother of fourteen was attacked. Five weeks after this the two remaining children of the family contracted the disease. The next case was a boy in a family living 300 yards from the first, and the next was his seven-year-old sister.

In the third family, living half a mile from the first, a boy of eight and his sister aged four had the disease.

¹ *Am. Pract. and News*, Aug. 6, 1887.

² *Cincinnati Lancet-Clinic*, March 19, 1887.

The fourth family invaded lived on the opposite side of the stream from the last, and about a mile away. The three younger children were first taken, and after an interval of five or six days the three older were prostrated by the affection.

There were fourteen cases in the four families. All recovered. The disease did not spread beyond these four families, who were related to each other. While the children of the first family were sick, members of the other three were calling daily to inquire after them, so that by this means the disease was doubtless extended.

Conditions favoring malaria are thought by many to develop a particularly malignant type of pneumonia, and Elliott¹ records a marked epidemic of pneumonia in the fall and winter, following an early overflow of the Ohio river, which killed standing crops and left an immense amount of decomposing vegetation about. That decomposing vegetation and moisture are not essential to the production of infectious pneumonia the following account by Dr. D. P. Hogshead, of West Berkeley, Cal., will show:

"In September, 1884, I treated a family living far out in the hills of Northern California. The household numbered twelve—father, mother, and ten children. Within less time than a month ten of the family were sick. Six of the number escaped with bronchitis and pulmonary congestion of different degrees of severity, while four of them suffered with acute lobar pneumonitis.

"These four were attacked within a few days of each other. In three of them the lower lobe of the right lung alone was affected; in the fourth the inflammation extended to the lower lobes of both lungs.

"I was never able satisfactorily to account for this epidemic (?) of pneumonia. The home was forty miles from the sea-coast, at an elevation of about twelve hundred feet. It was located on the southern slope, was free from fogs, warm and dry.

"The sickness occurred at a season of the year when, owing to the excessive dryness of the soil and atmosphere, very little decomposition or putrefactive changes are taking place. The sanitary conditions about the premises were as effectual as they had ever been before, or have since been. I

found one defective, obstructed sewer near the house, where the waste waters from the kitchen and wash-rooms were allowed to stand and become impure. This I had rectified. The family has since enjoyed uninterrupted health."

The advocates of the malarial theory of course will take comfort in the "defective sewer" in this instance, but it aids them less than it does the supporters of the germ theory.

It is very likely true that antiperiodic medication may be of almost specific value in intensely malarial regions, but the so-called pneumonia in malarial regions is often not pneumonia at all, as one who lives in such a country testifies. Dr. W. W. Taylor, of Memphis, Tenn., writes:

"I have been called to this kind of a case: The patient has suddenly had a chill, followed by fever, with pain in the side, free expectoration of blood, and abundant crepitant râles. In a few hours the fever subsides, and there is then an improvement in both local and constitutional symptoms. Without proper treatment, another paroxysm will occur in twenty-four or forty-eight hours, and the patient will die in the third or fourth attack. Quinine, given promptly and freely in such cases, will prevent a return of the paroxysm, and the patient goes on to recovery at once. There is also a remittent form of pulmonary engorgement, in which, while there is not a disappearance of the local symptoms of the disease, there is generally a periodical improvement in the symptoms, and in the patient's general condition, with a decline of the fever. However, in the majority of the cases I have treated I have failed to discover the characteristic rise and fall in the temperature, or the other leading features of malarial manifestations."

That malarial and pneumonic diseases thrive in the same environment there is no doubt. Dr. W. P. Geike, of Ontario, in a paper on "Pneumonia as Met with in Various Parts of the Dominion of Canada," asserts that both diseases are very rare in the Great Northwest and in the Province of Quebec.

The presence of a peculiar micrococcus in pneumonic sputa and patches is pretty constant, and is considered by many² a

¹ *L. c.*

² *N. Y. Med. Record*, April 9, 1887.

³ *N. Y. Med. Jour.*, April 30, 1887.

⁴ *Med. News*, Sept. 10, 1887.

⁵ See *London Med. Record*, April 15, 1887, articles 6699 and 6757.

conclusive diagnostic sign, but a far better proof of its infectious nature is its close connection with septic affections which it is seen both to precede, co-exist with, and follow.

Perret thinks¹ that clinical data prove the contagious, infectious nature of pneumonia. His experiments teach him that pneumonia can be produced by different microbes. Partly proving this he cites the concurrence of malignant endo-carditis and pneumonia; and notes the fact that the different infectious diseases, such as typhoid fever, measles, scarlatina, etc., are often complicated by pneumonia. Such being the case, it is rational to conclude that the pathogenic microbe of these affections is also the cause of the local affection of the lung.

THERAPEUTICS.

Perrenot on the Chloride of Camphor.—The chloride of camphor is obtained by passing a current of chlorine through an alcoholic solution of camphor. It has moderate toxic qualities, when given by the mouth, producing symptoms analogous to those of strychnine. The author claims it to be antiseptic, having the advantage of being unirritating, not easily absorbed, and preventing suppuration. It lessens vinous fermentation, but, like iodoform, is harmless to the *torula urinae*. It checks the development of the microbe of osteo-myelitis, the virus of anthrax, and that of hog cholera. The author speaks well of its action as a surgical dressing, producing no erythema, as does camphor, and having no odor as does iodoform.—Thèse de Lyon., in *Rev. de Thérap.*, June 15, 1887.

Jackson (E.) on the Action of Ste-nocarpine.—It seems to me that this drug does possess certain powers, in degree at least, peculiar to it. My impression, from my present experience, is that the solution used, said to be a two per cent. solution, is a more powerful anæsthetic than the four per cent. solution of cocaine. It certainly has a more powerful influence on the frog. The frog killed by two grains of this solution had withstood the action of four grains of the four per cent. cocaine

solution. And in a series of some thirteen parallel experiments performed on frogs with these two drugs, cocaine always showed itself the less powerful. Yet this new drug has seemed to exert less influence on the local circulation and the nutrition of the cornea than cocaine.

Then, too, cocaine has but little power of paralyzing the accommodation, while this new anæsthetic-mydriatic has a much greater power in this direction. Still the recovery after the use of the new drug is more rapid than after any other efficient mydriatic, except homatropine, and it has a more powerful influence over accommodation than homatropine. The superiority of the new drug in this direction is especially manifest in its ability to overcome the influence of eserine, and its influence on accommodation by still less. Homatropine is neutralized by one eighth its weight of eserine. But this drug requires two thirds or four fifths of its weight of the myotic to overcome it.

If it is a local anæsthetic more powerful than cocaine, and a mydriatic more powerful yet brief in its action as homatropine, it must be a new drug, and one of great practical importance.—*Med. News*, Sept. 3, 1887.

Villi on the Hypodermic use of Sulphurous Acid.—By passing a stream of sulphurous acid gas through liquid vaseline, the author has succeeded in making a solution of sulphurous acid of strength varying somewhat in proportion to the temperature, from 1.3 to 1.5 %. Hypodermic injections of this liquid never gave rise, in the writer's experience, to any local accidents. He injects 30 to 45 grains at a time.

His trial of the drug is too limited yet to draw many conclusions from, but he is convinced that the drug lessens cough and expectoration.—*Bull. Gén. de Thérap.*, Aug. 15, 1887.

Morse (W. H.) on the Application of Hydriodic Acid.—I do not think it any exaggeration to say that this acid not only produces the peculiar alterative effects of iodine, but it is given as a perfect substitute wherever the iodide of potassium is applicable, without provoking iodism.

Its effects are marked in the treatment of asthma and bronchitis. It is recommended in gout, useful in chorea, and efficacious in malarial disorders. For rheumatism, both chronic and subacute, we

¹ *London Med. Record*, Oct. 15, 1886, p. 454.

² On Experimental Pneumonia.—*Lyon Med.*, June 12, 1887.

have no better remedy. In the various forms of syphilis, I care not to prescribe the iodide with the syrup at my hand. Its use in lead and mercurial poisoning, and in eczema, is attended with marked success. Indeed, there are few diseases in which it has not been used, and with the conclusion that it certainly produces all of the constitutional effect of iodine, due allowance being made, of course, for the variable effects on the system, arising rather from idiosyncrasies than from the quality of the medicine itself.—*Maryland Med. Jour.*, Aug. 27, 1887.

West (S. L.) on Porpoise Oil as a Cod-Liver Oil Substitute.—The therapeutic use of an oil from the cetaceans as a cod-liver oil substitute is not a new idea. Dugong-oil, which is yielded by an herbivorous cetacean of the waters of Australia and the Eastern Archipelago, has all the qualities of cod-liver oil, without the repulsive taste, odor, and the tendency to decay. The dose is the same in quantity as cod-liver oil.

Recent experiments of mine have shown that oil from the *Tursiops tursio* has all the medicinal virtues of cod-liver oil, and can be taken without nausea by the most delicate stomach. It is easily and readily digested and assimilated. It is free from fishy smell and taste so objectionable in cod-liver oil. It is more nutritious, thereby furnishing new material to the system in greater abundance than any other known oil.

Some of the diseases in which I have found it especially adapted and advantageous are phthisis pulmonalis, emphysema complicated with asthma, scrofula, with or without tuberculosis, and rheumatism. A most distressing case of vesicular emphysema complicated with asthma was most rapidly and promptly relieved by a dessert-spoonful of *oleum delphinidæ* and spirit. frumenti, thrice daily. In one week patient experienced marked relief, and in a month could lie down and sleep in comfort, which he had not done for more than three years; appetite improved, accumulation of flesh followed, and the patient considered himself quite well. Cod-liver oil plain and in emulsion had been administered for months, but without perceptible benefit. In sub-acute rheumatism, *oleum delphinidæ* locally applied acts promptly in relieving pain and stiffness of joints and muscles. In infantile bronchitis (acute), given internally and

applied locally over chest it gives almost immediate relief, in twenty-four hours almost entirely removing the dry cough.—*Med. Standard*, Aug., 1887.

Coghill (J. S.) on the Chlorate of Potash.—After an historical résumé of the introduction of this agent into modern therapeutics, he discussed the various theories which have been advanced as to its action, and rejected the idea that it was decomposed and yielded its oxygen to the blood. Experiments were detailed upon the human subject, from whom nearly all the salt given was afterward obtained from the urine. "As a salt exceptionally rich in oxygen, it has, without decomposition, the valuable property *per se*, by its mere presence, apparently by oxygenating or aerating the blood, and so, by restoring or exalting this vital character of the circulating fluid, influencing to a corresponding degree the nutrition and functional activity of the various tissues and organs of the body. Beyond this it does not appear to have any specific action in any disease." The beneficial effect of this agent upon inflammations of the throat and other mucous membranes has been established by experience. The ordinary lozenges are too strong, and are liable to exert a caustic action upon the mouth; he uses only two and a half grains in each troche, with white sugar. This, in combination with arsenic internally, is almost a specific in clergyman's sore-throat. It is a valuable tonic and stimulant in cases of cardiac debility and impoverished blood, as in anæmia and chlorosis. It is remarkable what effect this has upon the development of the fœtus, when given during the whole course of pregnancy. Several very interesting cases were cited.

In the discussion following, it was suggested by many participants that the sodium salt would be found as efficacious, and much safer.—*N. Y. Med. Record*, Sept. 10, 1887.

Wild (R. B.) on the Action of Quinine and Allied Substances on Contractile Tissue.—To summarize the results of my experiments, I believe that quinine acts essentially in the same manner on all forms of contractile tissue. In small doses it stimulates, as shown in the heart, the increased height of contraction of voluntary muscle, and the initial contraction of the vessels.

In larger doses, or after longer action of

small doses, it completely paralyzes the contractile power of the tissue ; this is seen in the arrest of amœboid movement, the cessation of response to stimuli in voluntary muscle, the stopping of the heart in diastole, and the dilatation of the vessels.

In very large doses, or after prolonged action, quinine causes contractile tissues to pass into a state of rigor mortis, as shown by the small spherical condition of leucocytes, the rigidity of voluntary muscle, the contracted state of the heart, the secondary contraction of the vessels after long exposure to the poison, and the contracted state of the œsophagus.

Voluntary muscle (that is, the tissues in which contractility is developed to its greatest extent) was most susceptible to the action of quinine, and was thrown into rigor mortis by solutions which produce paralysis only of the less specialized tissues ; with strong solutions (for example, 1-1000) voluntary muscle passes into rigor mortis so rapidly that the period of paralysis is abolished, and the tissue, after a short period of increased contraction, passes directly into a rigid and contracted condition.

I found cinchonine to act like weaker solutions of quinine ; cinchonidine had a similar but more powerful action on voluntary muscle than quinine ; quinine, on the other hand, acted as a direct depressant, the muscle dying with great rapidity.—*Br. Med. Jour.*, Sept. 3, 1887.

Idiosyncrasy in the Action of Morphine and Quinine.—Dr. H. N. Burr reports¹ a case of morphine idiosyncrasy. A woman of sixty-five had for years tried, for facial neuralgia, all sorts of remedies, with no relief. At length she consented to try a hypodermic injection of morphine, and one tenth grain was given. Sleep, followed by deep coma, with slow respiration and failing pulse, lasted for two days. A period of prostration, lasting for over two months, ensued, when complete recovery took place, and the neuralgia never returned.

Dr. H. C. Coe reports² peculiar phenomena following an injection of morphine. The patient was a young woman with acute gastro-enteritis. The writer injected five minims of Magendie's solution, between 7 and 8 P.M., with a happy effect. About

4 A.M. the injection was repeated, and six or seven minims were given with $\frac{1}{10}$ gr. of atropine. The patient complained of feeling faint and weak, and swooned, the respiration becoming slow, the pulse weak, and the pupils contracted. The application of faradism excited an attack of seeming angina pectoris, the pain of which seemed to arouse the patient. She remained drowsy all day, and remembered nothing that had occurred during the time of apparent unconsciousness. Subsequently, half-grain doses of opium in suppositories caused no bad symptoms.

Dr. C. H. Smith, of Lebanon, Ind., reports³ three cases of quinine idiosyncrasy. One case had simply an urticaria ; another had urticaria and very alarming dyspnoea ; still another had urticaria and severe cramps, with cold extremities. Similar results in this case followed the administration of cinchonidia. In no case did the dose exceed five grains of the sulphate.

Dr. John Aulde reports⁴ the following interesting case : Within the past few weeks he attended a lady suffering from double tertian fever, supposed to have been brought about by a visit to Atlantic City. The patient under consideration took at one dose eight grains of quinine sulphate, and in the short space of half an hour the skin began to burn and itch, and caused her the greatest uneasiness. Two hours later the skin looked like a piece of red flannel. In reply to an inquiry she said she had experienced two attacks previously, one after taking some kind of medicine three years ago ; and she added that when the doctor saw her he told her it was scarlet rash, and went out and got a broom and commenced sprinkling carbolic acid all over her and the room.

Auld (A. G.) on the Administration of Opium.—The problem is to get all the good effects of the drug, and yet to obviate the resulting headache, sickness, and loss of appetite caused by arrestment of the secretions of the alimentary canal. This, of course, refers to medium doses. For some time I have given opium in combination with ether with good results, ether being one of the most powerful secretion stimulants we know. I generally prescribe equal quantities of tincture of opium and spirit of ether, and though not claiming for this

¹ *Med. and Surg. Reporter*, Aug. 13, 1887.

² *N. Y. Med. Jour.*, Sept. 3, 1887.

³ *Columbus Med. Jour.*, Aug., 1887.

⁴ *Med. and Surg. Reporter*, Aug. 27, 1887.

a specific effect, think it a good and most useful mixture.—*Lancet*, July 16, 1887.

Stadler (W.) on the Treatment of Opium Poisoning by Nux Vomica.—

The author cites the case of a man who swallowed two grains of morphine, and, to be certain, over one grain of strychnia one minute after. While the action of strychnia predominated, it was kept so far in check by the morphine that mild convulsions only took place, and he fully recovered, without treatment, in a short while.

He says: "I determined to try this treatment in any given case, and, as it was, I had a very fair chance for it. Mrs. —, æt. sixty-four, was sick, and having given her repeatedly morphia, I thought I was certain that she could bear it well. One evening I directed one quarter grain of morphia every four hours. A messenger gave me next morning a very lucid account of her condition, and I could not doubt but that she was poisoned by the morphine. I had one grain sulphate of strychnia dissolved in a half ounce of water and went. Found her insensible. Respiration four per minute; pulse feeble, rapid, and irregular. I gave her in a quarter of an hour two hypodermic injections of the strychnia, one tenth grain each. Being able to rouse her, I then gave her every quarter of an hour one cup strong coffee, with infusion of capsicum and one tenth gr. strychnia. I noticed the first improvement in two hours, when the pulse got strong, almost bounding. In less than three hours the woman had taken in all one grain strychnia, when I, for the first time, noticed twitching of the extremities, when I desisted from giving her more. Only then the respiration improved to six, then eight, and then ten per minute.

Three hours after that, six hours after beginning of treatment, the respiration was normal, she was awake, and was feeling pretty well.

The lesson I received in this case was to the effect that I was giving the strychnia too slowly. If I were again placed in the same situation, I would commence by giving half grain at one dose, then following with one quarter and one eighth grain doses until the physiological effects of strychnia manifested themselves. But there I would stop, for fear of substituting spasms of the diaphragm for paralysis of the respiratory centres.

In three hours the old lady was out of

danger. Will atropia do such quick work? — *New Orleans Med. and Surg. Jour.*, Sept., 1887.

More (J.) on the Treatment of Morphinomania.—

With nitro-glycerine I give strychnine, ergot, or minute doses of digitalis. The "nitrite-acting substance"—nitro-glycerine—of itself is not sufficient, and a little tension help is obtained by the addition of digitalis, ergot, or strychnine. It is not merely the partial anæmia of the brain, or the mere blood fulness in the peripheral arterioles, which is to be removed, but it is the sluggishness of the peripheral current and the excess of blood in the venules and larger abdominal veins that gives the somatic and peripheral misery felt by all, or most, patients suffering from deprivation of their accustomed stimulant. The excessive sweating, so marked and constant a symptom, is evidently due to the hyper-venosity of the blood and the consequent imperfect tissue change, and in strychnine we have a remedy which, besides stimulating the vaso-motor centre, increases the excitability of the respiratory centre and thus prevents, according to Brunton, the accumulation of carbonic acid. The whole mystery of this induced ischæmia is, therefore, paresis of the vaso-motor and respiratory centres, from habitual over-stimulation resulting in an almost pathological lowering of blood pressure in those vessels carrying the nutrient and oxygenated blood; hence the patient feels for the time as one feels after a serious bleeding.—*Lancet*, July 16, 1887.

Waddell (J. C.) on Poisoning by Fifty Grains of Chloral Hydrate.—

A female, aged fifty years, was given by mistake the contents of a 3 oz. bottle, containing fifty grains of chloral hydrate, and one drachm of bromide of potassium. The patient was seen one hour afterwards, when she was found to be in a state of collapse, semi-comatose, cold, clammy, and almost pulseless. The conjunctivæ were insensitive; pupils medium dilatation; consciousness very slight, with low muttering, and rambling of ideas. The relatives had at once discovered the mistake, and were doing all that was possible to keep the patient awake, but the tendency to sleep was almost invincible. Pallor was extreme; lips and mucous surfaces very livid, and breathing feeble. Amyl nitrite was at once administered by inhalation, followed by an emetic of sulphate of zinc

with injection of apomorphia. The stomach pump was at once applied, but the organ was empty; it was not washed out, the drug having evidently fully entered the system. Strong coffee was next injected into the rectum. Vomiting not having occurred, the emetic and injection of apomorphia were repeated, when vomiting took place, followed by total prostration. Sulphuric ether—twelve minims—was injected, with immediate effect. Several times the patient appeared about to die, when the sulphuric ether was injected, and amyl nitrite given to inhale, with, in each instance, almost instant effect. Earlier in the treatment $\frac{1}{16}$ th grain of strychnia was injected.

The patient was kept awake by every means possible, walking about, engaging in conversation, pinching tender surfaces, and strong coffee was given to drink. After about four hours the pallor began to disappear, and circulation began to be re-established, but intense drowsiness continued. An hour or two later the patient, still very drowsy, was allowed to drop asleep, remaining in a semi-torpid uneasy condition for about eighteen hours.—*Provinc. Med. Four.*, Sept. 1, 1887.

Felix (J.) on the use of Caustics in Surgery.—The author has compounded a caustic paste of the following ingredients :

Starch	37 parts.
Wheaten flour	112 "
Chloride of zinc	110 "
Pure iodol	10 "
Croton-chloral	10 "
Bromide of camphor	10 "
Crystallized carbolic acid	10 "
Bichloride of mercury	1 part.

These ingredients, previously powdered, are mixed in a mortar and enough water added to make a paste of about the consistency of putty.

He claims the following advantages for his paste :

1. The pain is endurable and there is no general reaction.
2. The slough is hard and limited, detaches itself rapidly, or can be easily removed by instruments.
3. It has an alterative action and is markedly antiseptic.
4. It is a powerful hemostatic.
5. It is easily and accurately managed, not attacking the hands of the operator.
6. Being neither fusible nor deliquescent, it can be easily applied and left on a longer

or shorter time, according to the action desired.—*La Thérap. Contemp.*, Sept. 2, 1887.

Trelat (U.) on Hemorrhoids and the Actual Cautery.—The patient being anesthetized and placed upon the side, the sphincter ani is stretched by a dilating speculum. The hemorrhoids, which have pedicles or are very salient are then seized with red-hot irons, similar to large curling tongs, and instantly destroyed. Smaller and flatter growths are simply touched by a smaller and more manageable iron. Extreme care must be exercised in avoiding an unnecessary destruction of mucous membrane or in burning the anal margin.

Cicatrizatio, the author says, is prompt and healthy.—*Le Prog. Méd.*, June 18, 1887.

Illingworth (C. R.) on the Biniodide Treatment of Scarlet-Fever.—Taking two ounces of the bichloride of mercury solution, I carefully added a few drops of a 1 in 4 solution of the iodide of sodium or potassium, shaking the mixture after the addition of each drop, until I secured a cloudy-red liquid indicative of the precipitation of the biniodide. To this I added half an ounce of glycerine for the purpose of keeping the particles of biniodide in suspension. This mixture I applied twice a day with a straight brush in some severe cases of scarlatina anginosa, with the effect of arresting the inflammatory and ulcerative action in a very short space of time. I also injected some of it up the nostrils in one very severe case, in which the disease had extended behind the soft palate, and was causing profuse discharge from the nose, and with excellent effect. In cases where it might be thought advisable to make more frequent applications to the throat, the biniodide thus prepared might be easily applied by the nurse or mother of the patient with a little help. My practice is to introduce the handle of a tablespoon well back on the tongue, and then to apply the brush rapidly and vigorously to the affected parts of the throat.

I should think that the same application would prove of great service in diphtheria also.—*Brit. Med. Four.*, Sept. 3, 1887.

Hutchison (J.) on the Tincture of Siegesbeckia Orientalis in Ring-worm.—I never prepare the affected part, as I find that the mixture cleans the place, while at the same time it kills the parasite. The red blush which is produced during the application, and which causes an amount

of alarm in some people, is of no moment, and I never found it remain longer than a day or two after the medicine was stopped. Though my usual prescription is tincture of siegesbeckia and glycerine, equal parts of each, I see no reason why in obstinate cases the siegesbeckia might not be increased to three quarters and one quarter of glycerine. The tincture as supplied to me is of the strength of 1 in 8. To use the drug properly, it must be well rubbed into the diseased portion of the skin several times a day, not merely painted on.—*Brit. Med. Four.*, Sept. 3, 1887.

Bundy (A. D.) on Resorcin in Phlegmons and Erysipelas.—The author has used a 20-per-cent. ointment of resorcin in lanoline in various erysipelatous conditions, with, he claims, excellent results. Sometimes he scarifies the part before he applies the ointment, and generally surrounds the part with plain or salicylated cotton.—*Med. Register*, Aug. 13, 1887.

Dodge (C. L.) on a Case of Chancroid Successfully Treated with Mercury.—To a chancroidal-looking sore on the prepuce the author had made all the commonly successful local applications without avail. He then put the patient upon 5-grain doses of mercury and chalk three times a day, and in less than a week decided improvement had taken place. In three weeks complete healing took place, when treatment was stopped. Fifteen months later no secondary symptoms had appeared, but the writer is still in doubt as to whether he had a chancre or chancroid to deal with.—*Therap. Gaz.*, July 15, 1887.

Pigornet on the Salicylate of Soda in the Treatment of Gonorrhœal Orchitis.—In his thesis the author claims that complete relief from pain can be brought about in a few hours by this treatment. This action is almost sure in cases of acute epididymitis with hydrocele. When the inflammation is located in the cord this medication often fails. Complete recovery, with perhaps some slight induration of the epididymis, ensues in less than eight or ten days.—*Bull. Gén. de Thérap.*, April 30, 1887.

Henry (F. P.) on the Medicinal use of Thymol.—Following the suggestion of Martini, in the *Annali Universali di Medicina e Chirurgia* for February, 1887, I have recently prescribed thymol in a number of cases of intestinal diseases, catarrhs, acute and chronic, and typhoid fever, with the

result of convincing me that it is a valuable adjuvant to our treatment of such affections.

The medicinal use of thymol is based upon its well-known antiseptic properties, and its action in the cases under consideration was favored by its great insolubility, which enables it to reach the intestine, mingle with its contents, and neutralize the toxic ptomaines that are formed in great quantity in catarrhs of the gastro-intestinal tract. In the opinion of many authorities, it is to the absorption of large quantities of these toxic products of fermentation and putrefaction that the so-called typhoid symptoms are largely due. These opinions do not rest solely upon theory, for it is found that, during the administration of thymol, phenol, which is one of the most constant products of intestinal putrefaction, and is almost entirely eliminated with the urine, is no longer found in that excretion.

I have always prescribed the thymol in pill, of which the best excipient is medicinal soap, and, so far, have not given more than thirty grains in twenty-four hours—two two-and-a-half-grain pills every six hours. This is a small dose, but I have seen no reason to increase it. This may be done, however, with perfect safety, and, perhaps, with still better results. It has been administered, with brilliant results, by Bozzolo, in cases of anchylostomiasis, in doses of from ten to twelve grammes (two and a half to three drachms) per diem.

The only case in which I found the drug to produce any unpleasant effect—slight digestive disturbance—was that of a woman with advanced phthisis, chronic diarrhœa, and who was, besides, the hostess of a tapeworm. Thymol has been found to be an excellent tæniifuge by several Italian observers, and it was for this purpose that I prescribed it in the case last mentioned. The woman had voided no fragments of the worm for two weeks, and it was a question whether the parasite had been entirely expelled. Although but a few doses of the thymol were tolerated, they were quickly followed by the expulsion of several fragments of the worm.

Martini, whose experience with thymol has been large, has only found it to give rise to unpleasant symptoms—delirium and stupor—in one case, that of a girl, æt. fourteen, to whom thirty grains had been given in the course of two hours; the

symptoms were transient, the treatment was resumed, and the case, one of typhoid fever, recovered without further mishap.—*Med. News*, Sept. 3, 1887.

Dupré (G.) on the Oxide of Zinc in the Treatment of Diarrhœas.—The author employs a modification of Gubler's formula as follows :

Sublimed oxide of zinc, gr. i.
Bicarbonate of soda, gr. lxx.
Tincture of rhatany, gtt. x to xx.
Simple syrup, ℥ ij.

For adults a tablespoonful is given every half hour p.r.n.

For children only one ounce of the syrup is put in the mixture, and the dose is a coffeespoonful.

The author has employed this remedy successfully in cholera morbus, intestinal catarrh, dysentery, intestinal tuberculosis, diarrhœa from worms, and cholera infantum. Of this latter ailment he has treated 234 cases with only 11 deaths—a mortality of only 4.7 %.—*Un. Med. et Sci. du Nord-est.*, Aug. 15, 1887.

Robinson (J.) on the Treatment of Epistaxis.—The hemorrhage in the vast majority of cases proceeds from the septum nares, and is supplied by a branch of the facial, which ramifies upon the septum nares. It enters the opening of the nose just below the alæ nasi, crossing the superior maxillary bone at that point.

Now, in a practice of nearly thirty years, I have had many cases of epistaxis, and have never in a single case failed to arrest the bleeding by compression of the aforesaid artery, with the finger applied over its track, making firm pressure against the bone.—*Therap. Gaz.*, Aug., 1887.

Florain on the Use of White Nettle as a Hemostatic.—The author has obtained with this drug success in the relief of metrorrhagia where ergot, alum, tannin, and the perchloride of iron have failed. He employs the following formula :

Tincture of white nettle . . . 100 parts.
Simple syrup 50 "
Water 25 "

A teaspoonful every half hour until the hemorrhage ceases, and then the same dose every four hours. The effect of the plant seems to be due to the presence of tannic and gallic acid.—*Rev. Méd. Chir. des Mal. des Femmes*, July 25, 1887.

Haussmann on Atropine in Hemoptysis.—The author cites three cases in which this remedy produced excellent re-

sults. The first was that of a patient who had serious hemoptysis twelve times in six days ; three milligrammes of sulphate of atropine were injected ; there was no recurrence of hemoptysis. The same result was obtained in the second patient, in whose case the administration of turpentine preparations and injections of ergotin had produced no improvement. In the third case a patient suffering from repeated hemoptysis was cured by two subcutaneous injections of three milligrammes of sulphate of atropine.—*Brit. Med. Four.*, Sept. 3, 1887.

Kollock (C. W.) on the Toxic Effects of Small Doses of Duboisine.—Chadwick has reported¹ a case in which $\frac{1}{10}$ gr. of the drug "instilled for examination of a senile cataract, produced a state of delirium lasting many hours, leaving the patient totally unconscious of what had occurred. There was great muscular weakness, and strange actions were performed."

In the latter case a solution of duboisia sulph. (gr. j to aq. dest. f 3 ij) was prescribed for the purpose of examining the refraction of the eyes. One drop was instilled in each eye at 2 P.M., after which the patient took a nap. He awoke feeling somewhat dizzy, but had another drop put in each eye at 4 P.M. Upon going to dinner soon after he became so dizzy and blind (as he expressed it) that he was obliged to leave the table and lie down. I saw him about an hour later—three hours after first instillation. He was in bed, face flushed, pupils widely dilated, and body moving uneasily from side to side. Although apparently rational, his speech was thick, and remarks frequently without meaning or irrelevant. There was no headache, but mouth and throat were very dry, and he drank copiously of water. I directed that he be kept quiet, and that no more of the drug be used.

The next morning he came with his sister for examination, having fully recovered from the toxic effects of the drug. His sister, a bright and intelligent young lady, told me that although he seemed at times sensible, still he did not get quietly to sleep until 5 A.M., and that he continually talked to her as if she was some one else, but when asked who she was, invariably said "sister." The patient had no recollection whatever after leaving the dinner-

¹ *Lancet*, Jan. 8, 1887.

table about 4 P.M., until late in the night, and did not remember my call, though he answered questions rationally. He said that he frequently wished to address some particular remark, but almost invariably said something else, and, though aware of his mistake, could not correct it.—*Med. News*, March 26, 1887.

Poisoning by Datura Seeds.—On the 12th April last, Moti Ludha, the husband of the guilty woman, one Rehmoovullee, a dealer in ghee, and a young woman named Rasul, left their village of Sela in the morning for the purpose of fetching ghee from another village. Halting outside the first village they came to, they sat down to partake of their frugal meal. The girl sat apart and ate her *bajri* bread, while the two men sat and shared their own bread together, and gave the fragments to the girl, who subsequently made them over to the police. Later in the day, as the party were proceeding in the afternoon towards Checkla village, the two men became giddy, began to stagger, and behaved like madmen. They soon became speechless and fell down on the road. The girl ran for assistance to the village of Checkla, but on her return both men were found dead. A post-mortem examination showed that they were poisoned with datura seeds, as they were detected in the pieces of bread left uneaten. The bread had been prepared by the accused for her husband the night before he started on the journey. The prisoner was found guilty of murder and sentenced to death, subject to the confirmation of the High Court. The motive for the murder was that this woman was carrying on an intrigue with another man, and wished to get her husband out of the way.—*Med. Press*, Aug. 24, 1887.

Dunlop (A.) on an Overdose of Eserine.¹—In a woman of sixty a solution of the strength of one gram to the ounce was prescribed and a drop was ordered to be placed in the eyes twice a day. The druggist put up a solution of gr. i to 3 i. At about 4:30 the same afternoon the first application was made, and a small drop of the solution placed in each eye. A good deal of smarting and lachrymation followed, and as this passed off, in about a quarter of an hour severe clonic spasm of the eyelids set in; the upper eyelid, as the patient

described, falling down on the lower every few seconds. About a quarter of an hour later a feeling of spasmodic stiffness in the lips, especially the upper, set in, and soon there was the same sensation under the jaw on the left side. Within an hour there was a feeling of tremor or spasm, but without any actual muscular movements in the arms or thighs, and at the same time there was a sensation of pressure on the eyeballs and of weight and pressure within the head. The patient also began to suffer from some mental confusion, and her memory was impaired. By 11 P.M. the movements of the eyelids had diminished considerably, but the other symptoms had altered very little. She slept uneasily, waking at frequent intervals during the first part of the night, and when she awoke was conscious of the same sensation, though in diminishing degree. In the morning the muscular sensations had disappeared, but she felt weak and shaken. I saw her a little before noon on the 20th, when I found the pupils contracted to a fine point, and the conjunctivæ a good deal injected. All the spasmodic muscular feeling had disappeared, but she complained of the pressure on the head and on the eyes. She said there was some mental confusion and a general feeling of weakness. Next morning, the 21st, the pupils were still minutely contracted, and as she still complained of the pressure on the balls I ordered a weak atropine lotion, at the same time advising her to go out for a drive. On the morning of the 22d she told me that after her drive, and before using the atropine, the weight in the head and the pressure on the eyeballs passed off, and that she felt stronger and better. The pupils were now pretty fully dilated after two applications of the atropine lotion.

A weak atropine solution was ordered, which removed the sense of weight in the head and pressure on the eyeballs.

[A more recent writer² has seen nausea and vomiting follow a single application of a 1 % solution of eserine.]

Blackwell (E. T.) on Tobacco; Safe and Unsafe Methods of Exhibition.—There is no drug included in the *Materia Medica* of which it is more necessary to be careful in regard to its introduction into the human system, a carelessness which shall result in the absorption by the tissues of

¹ *Lancet*, March 26, 1887.

² *Br. Med. Jour.*, Sept. 3, 1887.

just the amount required to accomplish a therapeutical result and no more, than tobacco. There is one method of exhibition spoken of by medical writers, in which this exactness can rarely be attained; in which the drug once given passes from the control of the person administering it, and is liable to cause the gravest condition, even death; I mean the injection of the infusion into the rectum.

So little is tobacco used by medical practitioners of the present generation, that few of them, perhaps, have witnessed the utter relaxation which it produces in the human system—an unharnessing, so to speak, of the muscular apparatus, which follows the administration of no other drug. While yet young in the practice of my profession, I encountered two desperate cases of incarcerated hernia, which called for the most powerful relaxant known to medicine. I chose tobacco; and was happy in eschewing the infusion, and using the leaf,—the ordinary cut tobacco—as a suppository. The results, I cannot but esteem brilliant, even in the light of the appliances of the present day,—relief being obtained in a very short space of time. On one occasion, in which a hernia in one of the cases referred to had resisted for many hours the best directed efforts of some capable physicians, I was pleased to find the protrusion released within an hour by the aid of the suppository. So complete was the paralysis of the sphincter ani, that it had released its grip of the tobacco, which was found lying outside,—the anus being open sufficiently to admit a finger. The application had proved to be self-regulating,—coming away when no longer needed. The amount of the drug used was about sufficient to fill the bowl of the common smoking-pipe,—estimated at 12 grains. The particles were held together by threads wrapped about them,—the ends of which being allowed to protrude afforded a suitable means of withdrawal.

In the *Medical and Surgical Reporter*, March 24, 1860,¹ I related two cases of strangulated hernia, to which reference has already been made, in which the incarcerating structures gave way under the use of the tobacco suppository. They are very striking and, I think, instructive cases; and, as they will be new to the greater part of the present race of practising physicians, I take the liberty of reproducing them.

J. C., aged 75 years, had an inguinal hernia of long standing. It became incarcerated on the 29th of August, 1854. The size and tension of the tumor were extreme. All known methods of reduction unsuccessfully exhausted, I introduced a suppository of tobacco. In a short time the tumor had palpably relaxed, and soon entirely yielded. On the 4th of September following, he had a relapse. By all the usual means, skilfully and perseveringly applied by two neighboring practitioners, together with the exhibition of chloroform, it proved wholly irreducible. I saw him at 4 P.M., and determined to try the remedy which had once before relieved him. In about one hour from the employment of the suppository, the tension was so much lessened that a considerable part of the protruded mass was returned by taxis; and soon after, whilst waiting events, the remainder of the tumor spontaneously subsided.

J. M., aged 70 years, has also had inguinal hernia from youth. Twenty years since, it became strangulated, and relief was obtained by an operation. In November last (1859), at 7 o'clock A.M., he had a protrusion, and was unable to return it. He was at once seized with excruciating pain in the abdomen. In his own nervous language, "the pain went right to his heart." Syncope followed, and he lay as one dead; and such his friends reported him. On my arrival, at 11 o'clock, A.M., he lay motionless and deadly pale. Consciousness had returned, and his breathing was imperceptible. His pulse was soft and regular. The tumor equalled in size the head of a newborn infant. It was tense to the last degree and elastic. The patient was confident the operation must be repeated, and accepted that as an alternative. After trial by taxis, sufficient to prove its utter inefficiency, I applied the tobacco and calmly awaited restoration. In about an hour the incarcerated part was liberated; and, unassisted, swept into the cavity of the abdomen. There were no unpleasant sequelæ in either case.

All the cases reported of poisoning by this drug have resulted, so far as I have learned, from faulty methods of exhibition; or from the use of an inordinate dose. In the cases stated by Pereira, as coming under the notice of Sir A. Cooper, Sir Charles Bell, and Dr. Copland, one drachm in clyster proved fatal, in each case. Pereira also relates that a half drachm in infusion has caused death. Desault has seen a like

¹ Vol. iii., p. 559.

result from an enema of the smoke of tobacco.—*Med. and Surg. Reporter*, Sept. 3, 1887.

Young (J. K.) on Recovery from the Toxic Effects of a Tobacco Enema.—The infusion was prepared from a pipeful of tobacco, in a pipe which had been in continuous use for four years, and consequently saturated with nicotine. Of this, about two fluid ounces were introduced into the rectum of a child four years old for the destruction of seat worms. Vomiting and tenesmus ensued almost immediately, a portion of the enema was ejected, and severe convulsions followed. When seen, scarcely ten minutes after the administration of the drug, the patient was in a severe general convulsion; respiration oppressed, pulse rapid, and pupils dilated.

The prompt administration of soap enemas, external rubefacients (repeated hot baths, sinapisms, etc.), with alcohol freely internally, were followed by a rapid improvement of all the symptoms, and recovery followed.—*Med. and Surg. Reporter*, Aug. 13, 1887.

Hue (F.) and Bruère (G.) on the Treatment of Pulmonary Tuberculosis by Inhalation of a Vapor of a Boiling Solution of Picric Acid in Water.—Attention was turned to this subject by the apparent recovery of a tubercular patient who worked in the fumes of picric acid.

Some of the drawbacks to its use are as follows: It corrodes metals and must be stored in wooden or earthenware vessels; it imparts a yellow tinge to the skin, necessitating a free use of soap and water after each inhalation, and it explodes when thrown into the fire. The taste of the acid is bitter, but that seems sometimes not to be a disadvantage by increasing the appetite. In some cases it produces vomiting. How much of its action is due to its febrifuge power it is hard to say.

Four cases were treated in this way with what the authors consider very flattering results.—*Gaz. Hebd.*, etc., May 13, 1887.

Holtzapple (G. E.) on Oxygen Gas and Nux Vomica in the Treatment of Pneumonia.—The author in combating the respiratory failure and asphyxia of pneumonia, concludes that strychnia best fills the former, oxygen the latter indication.

In cases of emergency he generates the oxygen by heating some binocide of manganese and chlorate of potash in a large

tube, conveys it by a rubber tube into a receptacle containing water, from which, as it bubbles, it is fanned into the face of the patient. He suggests the possible utility of oxygen in bad cases of whooping-cough.—*N. Y. Med. Jour.*, Sept. 3, 1887.

Payne (R. L.) on Mistletoe: its Physiological Action and Therapeutic Applications.—In the year 1851, Dr. Turnipseed, of South Carolina, called attention to the ecboic action of a decoction of mistletoe. But little attention was paid to the declaration. In the year 1878, renewed interest in the remedy was excited by an article written by Dr. Long (*Louisville Medical News*), in which the author speaks highly of the exytocic virtues of mistletoe, claiming it to be far superior to ergot:

1st. Because it acts with more certainty and promptness.

2d. That instead of producing a continuous or tonic contraction, as does ergot, it stimulates the uterus to contractions that are natural, with regular intervals of rest. Consequently, it can be used in any stage of labor, and in primiparæ where ergot is inadmissible.

3d. It can always be procured fresh, does not deteriorate by keeping, and is easily prepared.

Cases have also been reported by European authorities, in which children, after eating of the berries, were seized with vomiting, great thirst, tenesmus, bloody and mucous stools, and in one instance collapse and death. Further than the gastro-enteric irritation which the symptoms in these cases indicate, nothing was published throwing any light upon the physiological action of mistletoe until in the *North Carolina Medical Journal* (May, 1881), the writer published an extended series of experiments upon cold- and warm-blooded animals, from the results of which the following general summary of the physiological action of the drug was deduced, viz.:

Mistletoe is an irritant of the gastrointestinal mucous membrane. We also conclude that it exerts, in cold-blooded animals, an action on the heart similar to digitalis, slowing its action by increasing the length of its diastole, at the same time increasing the length of its systole. In warm-blooded animals its action on the heart is more like that of belladonna, its force not only being increased, but its rate

of impulse also, and—contradictory as it may seem—it must be that in frogs the heart is slowed by increase of its inhibiting control, and strengthened by stimulation of its vaso-motor ganglia; while in warm-blooded animals the increase in strength and rate of the pulse is due not only to stimulation of the vaso-motor cardiac ganglia, but also to a paralyzing action on the pneumogastric terminal filaments. It must also be noted that in too large doses, or if its action is too long continued, mistletoe, by over-stimulation of the cardiac motor ganglia, exhausts their irritability and paralysis results. The action of mistletoe on the pupil is also evidence of its stimulant action on the sympathetic nerves; and further, it is seen that in both cold- and warm-blooded animals, mistletoe exerts a paralyzing action upon the spinal cord and its nerves, both of sensation and motion, but the action upon the heart and pupil indicates a stimulant effect upon the ganglionic nerves. Whether this paralysis depends upon a specific action on the cord, or whether it be due to a diminished supply of blood, the result of the stimulation of the vaso-motor nerves and consequent contraction of the arterioles, cannot well be determined, but the latter hypothesis I am inclined to adopt.

Mistletoe destroys the reflex functions of the spinal cord and lessens the electro-motor contractility of muscles.

As a result, then, of this determination of physiological action, and knowing that the uterus, like all unstriped muscles, is almost entirely controlled by the ganglionic nerves, it is easy to understand the alleged oxytocic virtues of mistletoe; and since the publication of my paper above referred to, a number of trustworthy observers have testified to me of its efficiency. Indeed, I am prepared to endorse not only all that Drs. Long, Todd, Lane, and others claim for it in this connection, but I would further add that in those cases of post-partum hemorrhage in which the loss of blood has been extreme and the nervous shock so severe that we dare not give ergot, lest paralysis of the heart result, mistletoe, from its stimulant action on the heart, may be given with greater safety and with even more confidence as to the relief of the flooding, than ergot.

After an extended experience with mistletoe in cases of the retained placenta after abortion, I am fully persuaded that it will be found a most efficient remedy. Further, from its stimulation of the vaso-motor nerves and consequent contraction of the arterioles, mistletoe will be found to do good service in epistaxis, hæmoptysis, menorrhagia, metrorrhagia, and indeed all passive hemorrhages. That its action on the heart indicates its influence in all diseases of this organ characterized by weak action and low arterial tension, I have been able to demonstrate in practice, since I claimed for the remedy theoretical virtues in my former paper; and in *The Practitioner* (November, 1881), will be found a note on *viscum album* by Dr. Roswell Park, of Glasgow, who, referring to my paper, confirms my observations in this connection. Dr. Park states that "whatever the exact pathological condition might be, incompetency and tumultuousness, and distressing cardiac action were the immediate symptoms calling for treatment in those that presented themselves. For this I prescribed 3 ss doses of the tincture every four hours with the best results; all the patients returning with the above symptoms ameliorated." He further states that the drug is one of no mean "physiological power," and "an excellent substitute for digitalis."—*Med. and Surg. Reporter*, Sept. 10, 1887.

[Dr. J. S. Todd¹ says that mistletoe increases the natural, rhythmical, intermittent pains or contractions of the uterus, and that he annually begs his students to use it. Dr. Green, of Atlanta, uses a decoction of the mistletoe in tardy labor, and is delighted with the results, as it acted to increase only the length and tonicity of the pains, not notably affecting their frequency, and certainly followed by intervals of complete relaxation.]

Lucas (J.) on the Fluorides of Ammonium and Iron in Hypertrophy of the Spleen.—Believing, on physiological grounds, that the fluoride salts would probably prove as efficacious in the treatment of chronic splenic hypertrophy as hydrofluoric acid has done in the treatment of bronchocele at the hands of Dr. Woakes,² the author gave the former a trial a few years since and conducted a series of therapeutic and clinical experiments, of which he

¹ *Atlanta Med. and Surg. Jour.*, June, 1887.

² See "The Pathology and Treatment of Bron-

chocele or Goitre," *Lancet*, March 19 and 26, and April 2, 1881.

gives a brief summary. The ammonium fluoride (NH_4F) is prepared by saturating a solution of hydrofluoric acid (HF) with ammonia (NH_3), and allowing the mixture to evaporate over quick-lime. The fluoride of ammonium crystallizes in hexagonal prisms, dissolving readily in water, and the solution is colorless, but it acts on glass, going through it and escaping. To prevent this escape, the expedient of coating the inside of the bottle with wax, so as to prevent the unstable compound in solution from coming in contact with glass, has to be resorted to; or the solution may be kept in india-rubber tubes or gutta-percha bottles. The strength of the solution employed was four grains to the ounce. Of this *liquor ammonii fluoridi* he began with 5-minim doses, diluted in an ounce of water, and administered thrice a day after meals, and the dose after a day or two may be increased to 8 minims, then to 10, 12, 15, 18, 20, and so on, at intervals of a few days, the increase being effected gradually and cautiously; the great point to attend to is to ensure the taking of this medicine after food, as otherwise gastric and intestinal irritation will be set up, while with this precaution it will be found to be fairly well tolerated in the majority of cases.

Certain physiological effects, more or less common to all the cases, were observed. There was a marked influence on the blood-pressure, which had a downward tendency at first; the pulse fluctuated, and the number of beats was lessened. It was also found that the drug possessed antipyretic properties when the temperature ranged above the normal point, and it prevented attacks of ague, thus proving it to be an anti-periodic. In all cases it produced nausea at first, though gradually a sort of tolerance appeared to have been established, and the drug could be borne in much larger doses. It produces some intestinal irritation, probably acting more on the duodenum, and giving rise to some diarrhoea. The appetite after a time improves under its use. Almost all the patients complained of a prickling or twisting pain or uneasiness in the spleen itself, the original pain being sometimes aggravated. When given carefully and after meals, which should be the invariable rule, it is better borne and does not produce nausea and purging to the same extent. The combination of iron with hydrofluoric acid, I am inclined to think, would prove more

valuable on account of the hæmatinic properties of the former, and because as an adjunct it would exercise its astringent and tonic influence on the mucous lining of the stomach and intestines, and thus in a great measure tend to counteract the unpleasant effects complained of, and perhaps also to augment the evident specific action on the spleen. The fluoride of quinine can easily be prepared, and so also can the triple fluoride of iron, quinine, and ammonium.—*Practitioner*, June, 1887.

Hughes (C. H.) on Ammonium Picrate in the Neurotic Sequelæ of Malaria.—Braconnet some years since reported excellent results from the use of potassium carbazotate (picrate) in malarial affections, and Dr. H. M. Clark has lately extolled ammonium picrate as a quinine substitute in the malignant malarial fevers of Asia and Africa.

Every remedy which promises therapeutic power as a quinine substitute is eagerly seized upon by the neurologist, because of the untoward effects of quinine and its constitutional intolerance by certain neurotic individuals.

In malaria ammonium picrate has proven, in the writer's hands, a sufficiently salutary remedy to justify its commendation. Nervous patients, who feel cold or drowsy a part of every day, or every second or third day, or who are chilled by slight causes, and those who always feel tired and who give a history of antecedent malarial affection the previous spring or fall, are often markedly benefited by a grain or a grain and a half of ammonium picrate three or four times a day an hour after meals.

It is best given alone in pill or capsule form, but may be combined with ammonium muriate or capsicum. I have given it mixed in mucilage (it is not soluble in water), combined with compound hypophosphite syrup.

Ammonium picrate has neurotic tonic power which, in my opinion, is not due to its anti-periodic influence alone, but to its power over the vital nerve centres. I have in some instances seen brain and nerve-weary, and somewhat irritable, patients become more restful and tranquil under its use. It does not act rapidly like the opiates, bromides, or chloral hydrate, and I have not given it in large doses.

I have given it after a few days of quinine in nervous disease complicated by malaria, and have found that such a procedure often

yields prompt results. — *Med. Standard*, Sept., 1887.

Fuller (S. E.) on the Picrate of Ammonia in Malarial Fevers.—Having been for many years a sufferer from chronic malaria, and being at the time afflicted with an unusually severe attack, for which I had taken the usual remedies without receiving any benefit, I at once procured some picrate of ammonia, and began its use in half-grain doses (made into a pill with extract of gentian) three times a day. In three days' time there was marked improvement in all my symptoms. Had no more chills, pain in the head and back had left me, and I awoke in the morning without those terribly exhausted and irritable feelings which 'those who suffer from this disease so well know. This result encouraged me to make trial of the drug in several cases of similar trouble in which I had been using quinine, etc. I prescribed it for six adults, of both sexes, and kept watch of the effect. In all but one case the same marked improvement speedily resulted. I now began to notice a peculiar, deep-orange color in my urine, without any change in quantity, and a chemical analysis of it showed that except for the change in color it was normal. Upon inquiry I found that the urine of all the patients was of this same orange color. Having taken the medicine myself in doses as above mentioned for ten days, I decided to stop its use and watch for the disappearance of this color from the urine. To-day, May 24th, seven days since stopping the medicine, there is not the least improvement in the color of my urine, and the whites of my eyes, and the skin of my face generally, are the color of one mildly jaundiced. The same thing has occurred to all my patients who have taken the remedy for a week. One lady, to whom I gave the maximum dose, one and a half grains three times a day for eight days, is now deeply jaundiced, the color involving not only the whites of the eyes and the skin of her face, but also the skin of her neck and breast, from which, shading to a lighter color, it covers the rest of her body. In each case the tongue is clean, bowels not affected, and appetite good.—*Letter to Med. Record*, July 2, 1887.

Dr. Hughes, in a more recent communication¹ says of the jaundiced hue from picrate of ammonia :

"I have observed it both in sclerotics and in urine, but not so persistent or marked in my cases as appeared in Dr. Fuller's. All of my cases, having some neurotic trouble and the indications for the ammonia picrate being only incidental, were taking hypophosphites and ammonium bromide, and some iodide and arsenic. In those patients who happened to be taking murate of ammonia with other treatment, the yellow tinge to urine and sclerotics appeared very slight, and in some not at all ; and in all, the subsequent administration of the ammonium murate and suspension of the ammonium picrate cleared away the jaundiced hue in a few days.

"There was no cutaneous icterus in any of my cases.

"I attributed the change to the diffusion of the coloring matter of the picrate of ammonium through the tissues, as urinary examination showed nothing abnormal, and made this explanation (and still make it, when I use this salt) of this discoloration-phenomenon."

Phillips (C. D. F.) on the Action of Certain Drugs on the Circulation and Secretion of the Kidney.—The author has conducted a number of very interesting experiments with Roy's onkometer, using caffein, spartein, strophanthin, digitalin, and ulexin.

His results were tabulated briefly as follows, in three divisions :

(a) *Drugs that first Contract and afterward Dilate the Kidney.*

(1) Caffein—in small doses—induces in the stage of contraction a fall of blood-pressure ; in that of expansion, a slight rise. During the former, the flow of urine *may* be arrested ; during the latter it is always increased, such increase depending on dilatation of renal vessels.

(The possible *arrest* of secretion during the first stage is special to caffein, and may be induced by large or repeated doses.)

(2) Ulexin—gr. $\frac{1}{4}$ —greatly raises blood-pressure during the first stage (that of contraction) ; in the second, expansion is much greater in degree but shorter in duration than under caffein, and is accompanied by brief but marked increase in urinary flow ; the effective dose is limited by its toxic action on respiratory centres. Practically, *excess* of caffein induces only the first stage ; *excess* of ulexin only the second.

¹ *N. Y. Med. Record*, Aug. 20, 1886.

(b) *Substances that Dilate the Kidney, but to less extent and more slowly than Caffein and Ulexin,*

are dextrose, urea, sodium chloride and acetate, and probably all constituents of the urine.

(c) *Drugs that Contract the Kidney without subsequent Expansion.*

(1) Digitalin, with *increased* secretion of urine (probably resulting from general heightened blood-pressure).

(2) Spartein, with *diminished* secretion (in health at least).

(3) Strophanthin causes slight temporary contraction, with no marked increase of secretion.

(4) Apocynëin, similar temporary contraction, and no definite increase of secretion.

(5) Turpentine; (6) adonidin; and (7) barium chloride give similar results.—*N. Y. Med. Record*, Sept. 10, 1887.

Stockett (B. F.) on Digitalis Poisoning.—Mr. J., aged 40, cook, sent for me in haste on Jan. 8th. I found patient in bed, very restless, pulse 38, and very irregular and weak. Pupils contracted and fixed; eyes prominent.

Patient had a severe 'headache, which rapidly increased, making him almost frantic. The pain extended from the centre of the forehead, directly over the vertex, to the occiput, making a band, as it were, about two inches wide. There was a very sharp, cutting pain in the right temple, but none in the left. It seemed almost impossible for him to get his breath, as he so frequently said, and as shown by his continual gasping. Occasionally there were twitchings in the lower limbs, but he did not complain of pain in them. When I first came to the patient's side his mind was clear, and when spoken to would look earnestly at me, and his answer was slow, and seemed to be far-fetched, but positive and to the point. He told me he had been taking medicine for his kidneys for thirty-six hours, and that he began to feel very sick about an hour and a half before he sent for me (12:30 P.M.). I examined the medicine, and found it to be digitalis. I sent to town—one mile and a half—for some alcohol at once. Before alcohol arrived patient's mind began to wander, it being hard to get an answer from him.

The pain in the head in the meantime became almost unbearable. To relieve

this I applied cloths wrung out of hot water every four or five minutes, which gave entire relief in one and one half hours. Gave him a dose of mag. sulph. To keep up the heart's action till the alcohol arrived I gave him fifteen-drop doses of tincture of opium, with a very slight increase of heart-beats.

As soon as the alcohol came I dropped the tincture of opium that the bowels might act more quickly, and gave three teaspoonfuls each of alcohol and water every twenty minutes, which was kept up all night. The pulse continued very irregular until about 6 o'clock A.M., ranging in ten minutes from 45 to 56 per minute. At 1 o'clock A.M. he was aroused enough to say "I'm getting drunk." I tried to extend the alcohol to twenty-five minutes, but the pulse fell back to 40 beats the first interval, so the same time was resumed. As the magnes. sulph. did not act as it should, I gave him an injection of warm water, which produced a copious stool at once, with vomiting. About 6 o'clock the pulse began to steadily increase, and at 10:30 it was 74, and quite regular, breathing much easier and not labored.

He had ceased his groaning almost entirely, and was stupid, and began to sweat quite copiously. I then stopped the alcohol, as I pronounced it an alcoholic stupor, and left, with the directions to resume the alcohol should the heart show the least signs of failure—to keep him lying down and quiet. The next day he began to take nourishment, and on the third day (though contrary to my order) came to town. The altitude being 11,000 feet where he was, I advised him to go below to the valley, which he did the day he came to town. Have heard from him since, and he says he is working.—*Peoria Med. Mo.*, Feb., 1887.

Noer (J.) on Poisonous Symptoms from Nitro-Glycerin.

—On November 14, 1886, I was called to see Mrs. O. S., age 47. I found her in bed, propped up with pillows into a semi-recumbent position. Face was very pale, and general appearance indicated great prostration and dejection; skin was cold, and covered with a clammy sweat. Breathing slow and heavy. Pulse tense, rather slow (50 to 65), and irregularly intermittent. Temperature in the mouth was 99½° F. Pupils dilated, urine scanty, very dark in color, and passed with a great deal of pain and tenesmus at the neck of the bladder apparently. A hasty examina-

tion of the urine gave the following results : reaction neutral ; sp. gr. 1030 ; large deposits of solids, principally urates and phosphates. Heller's test gave a very copious deposit of blood-pigments in a test-tube. Auscultation of the heart revealed a peculiar loud booming, seemingly distant, sound, synchronous with the ventricular systole, masking almost entirely the second sound of the heart, while the ventricular contraction appeared to be greatly prolonged. The area of the apex-beat was greatly increased, while the sounds in the aortic region were almost entirely inaudible.

The patient complained a great deal of the pain in the region of the heart, which she said was sharp and intense. There was intense headache, with hammering sensation in the temporal region, and a constricting band round the forehead. There was also great weakness and muscular prostration. These symptoms, she stated, had been present for about three days.

I was at first unable to decide as to what to attribute these signs and symptoms ; but finally I concluded that they must be due to the action of some poison. I soon ascertained that my patient was an old asthmatic, and that she had about three weeks previous to my visit consulted an eminent European physician, who was at that time sojourning in a neighboring city. After examining the mixtures which she was taking, and reflecting upon the symptoms that they had evidently caused, I concluded that nitro-glycerin might very probably be the offending ingredient. I directed the patient to take no more of my predecessor's medicines, and prescribed Tonquin musk, gr. vi., in suppositories, to be used every third hour ; strychnine sulphate, gr. $\frac{1}{16}$, four times a day ; pot. iodide, gr. v., in solution after meals. In a few days patient expressed herself as quite recovered. Pulse was, however, intermittent, and urine contained traces of blood for over a week after my visit.

Upon investigation I found that Mrs. S. had been taking the following mixtures for two weeks :

℞ Sol. nitro-glycerin. alcoholic., 30.

Sig.—Ten drops night and morning.

℞ Decoc. lichen. island., 25–250

Pot. iodidi, 15

Pulv. Doveri, 5. M.

Sig.—One tablespoonful after each meal.

℞ Fumigatoires pectorales (Français), 1 box.

It is evident that the nitro-glycerin solution was the cause of the trouble with Mrs.

S. The directed dose of 10 drops had not been taken till a few days before I saw the patient, she having begun with a dose of 3 drops, and increased to 8 drops, which dose had been taken for some time. The 10-drop dose had been taken only a few times.

I think the physician may be open to criticism in this case, first, for prescribing a large and very uncertain dose (drops from a vial) of a dangerous, uncertain, and almost untried remedy to a patient that he never expected to see again ; and, secondly, for not warning the patient of the danger. His dose is a very large one, and I believe the patient stated that she had been cautioned by the druggist.

New and dangerous therapeutic agents ought not to be used by travelling physicians, nor by any physician who cannot see his patient frequently.—*Therap. Gaz.*, July 15, 1887.

Weller (E. K.) on a Case of Diabetes Mellitus, Promptly Yielding to the Influence of Cocaine.—Cocaine having a pacifying effect upon the brain and a most excellent remedy for the relief of polydipsia from other causes, I prescribed two drops of a four per cent. sol. every three hours, and an anti-diabetic diet.

After a few days the polydipsia disappeared and the urine was little above the normal quantity. The pruritus vulvæ was much less annoying. The itching and dryness of the skin was absent. The other conditions remained the same. I continued the same prescription, adding another for the anæmia and as a tonic, viz. :

℞ Tr. opii f 3 j
Tr. ferri chlorid. f 3 j

M. S.—Twenty drops three times a day in water after meals.

The patient was ordered to return in two weeks.

I saw the patient again in three weeks, when all the symptoms had disappeared. The anæmia was very much diminished, and she felt "as well as ever." The nervous symptoms had all improved, and the palpitation of the heart had not recurred once. I now continued one drop of a two per cent. solution of cocaine, and the iron. After using this treatment for a month longer, the case could be called cured, as all traces of sugar were absent when I made the last examination of the urine. I have since heard of the patient, and there is no return of the symptoms.—*Med. and Surg. Rep.*, Aug. 27, 1887.

OBSTETRICS AND DISEASES OF WOMEN.

Hervieux on the Medical Treatment of a Vaginal Fistula.—A woman of 23 had a pelvic abscess, following a difficult labor, which opened into the vagina, and left a fistula, which all efforts failed to heal in four years. A daily injection of Labarraque's solution to the bottom of the fistula, by means of rubber catheter, brought about a complete cure in five months.—*Rev. de Thérap.*, May 1, 1887.

Coles on Exfoliative Vaginitis.—Mrs. F., æt. about 30, and the mother of several children, was confined about two years since. Some ten or twelve months after confinement the menses reappeared. The flow at every period is quite profuse and lasts for a week or ten days. The patient complains at the same time of pain and a heavy uneasy sensation about the uterus and vagina. After cessation of the menses there is a disagreeable feeling of dryness and itching high up in the vaginal canal. The latter sensation is not intense as in pruritus, but is at times quite marked, and is referred to various points from the vulva to the neck of the womb. The patient presents somewhat of a chlorotic appearance, being thin, pale, and decidedly nervous.

The profuse menstrual discharge and other symptoms led Dr. Pearson about a year since to make a physical examination, and, to his surprise, he found it impossible to introduce his finger into the vagina, the entire canal, from the vulva to the uterus being filled by a membranous substance which he described to me as resembling the deposit of diphtheria or croup. It was only after considerable manipulation, aided by the free use of vaseline, that the finger or a small speculum could be introduced. The doctor found the vaginal portion of the cervix likewise covered with membrane, which so closely resembled the well-known exudations found in the throat and trachea, that he determined to treat the disease by the application of such local solvents as have been found most effectual in such cases. Of all these he informs me that he found a strong solution of pepsin to answer a better purpose than any thing else. This agent would dissolve and remove the entire membrane, leaving the vagina free and clean. But in from 36 to 48 hours the

membranous deposit reasserted itself. The uterine cavity has been freely swabbed with tincture of iodine and other equally efficient remedies.

When I saw this patient in September last the vulva, when viewed externally, presented no abnormal appearance; there was no apparent swelling, congestion, or moisture. Upon separating the nymphæ, numerous white patches were discovered occupying the vestibule, inner sides of the nymphæ and ostium vaginæ. When I attempted to pass my finger, there was manifested a considerable sensitiveness of the parts, with some little tendency to vaginismus. The vagina seemed small and corrugated, and was completely filled by a quantity of membranous material, that adjacent to the walls being attached, a large quantity also being detached and lying loose within the canal. To the finger this imparted the sensation of slightly moist, coarse bran. A considerable quantity of this had to be removed and the parts well lubricated with vaseline before the finger could be passed up to the os. The extraordinary dryness and harshness, due to an absence of the natural moisture of the parts, was very pronounced. On introducing the small blade of a Sims' speculum, the cervix and inner vaginal wall were brought fully into view. These parts were entirely covered by membrane, which presented a peculiar, fractured appearance, such as would be apparent if a piece of paper or parchment were painted with a solution of gum arabic or varnish, and then bent in various directions after the application was allowed to dry.

At each line of fracture, the edges of the membrane seemed to be partially detached, with a tendency to curl up. In size the individual pieces of membrane varied, some being quite small, while others, especially in the cervix, were as large as the finger nail. This fractured appearance was doubtless due to the mobility of the surface involved, and hence the lines of fracture were less numerous on the cervical surface. The os uteri was literally stuffed full of partially detached flakes of membrane. When this was removed by the forceps there was no evidence of membrane within the cervix or cavity of the uterus. The cavity of the latter organ was a little above the normal depth. The membrane at every point was easily removed by taking hold of the free edge with a pair of dressing forceps. It

left a slightly abraded appearance, with a show of blood or colored serum. The abraded surface of the cervix presented a somewhat livid, congested aspect.

The patient informed me that during menstruation large flakes of membrane are occasionally discharged; she says she has seen them of the size of a half dollar.

The fractured appearance of the membrane recalled the characteristic features of the well-known skin disease ichthyosis.

I submitted specimens, with a full description of the case, to several experts, and they all agree that it is probably non-parasitic, neither is it exudative in character, but simply an exfoliation of the natural epithelial layer of the parts involved.—*St. Louis Cour. of Med.*, May, 1887.

Beatty (W. J.) on the Removal of Large Encysted "Wedgewood" Ball Pessary from Vagina.—Mrs. H., aged sixty-eight, consulted me for enlargement of left groin, with an offensive discharge from vagina. She informed me that about sixteen years ago she suffered from falling of the womb, when she was examined by her medical attendant, who advised her to wear a ball pessary to keep the womb in position, and for which purpose he inserted a large wood ball pessary, ordering her to take it out every week and wash it. This she was able to do for about twelve months, but at the end of this period she failed to remove it, as, owing (she says) to its greasy condition, it kept slipping from her fingers, and as she had left the town where the doctor lived who inserted it, she felt a delicacy about consulting another medical man, and feeling no inconvenience, she simply syringed out the vagina two or three times a week. She was always able to move the pessary until about six years ago, and has never suffered any inconvenience except troublesome constipation, and latterly a constant desire to go to stool, until a month ago, when she felt a little pain in the left groin, and found a slight enlargement there, and about a week later had an offensive discharge from the vagina.

On examination I found an enlarged gland in left groin, and in the vagina a large round tumor only slightly movable, situated to the left and posterior wall of the vagina, over which I made an incision.

By fixing it against the perineum with the fingers of my right hand, I succeeded in expelling it by external pressure on the perineum with the palm of my left hand.

Since its removal the glandular enlargement has gone, constipation greatly relieved, and the constant desire to go to stool has quite disappeared.

The pessary had become quite soft, and I was able to make a section through it with an ordinary table-knife.—*Edinburgh Med. Jour.*, Aug., 1887.

Potter (W. W.) on Tamponnement of the Vagina in Pelvic Inflammation.—As a result of his experience he has reached the following conclusions concerning this method of treatment:

1. In retro-deviations of the uterus the reposition of the organ should be made in the genu-pectoral posture, without the aid of any other repositer than the finger; it should then be shored up and held in place by the multiple tampon. This treatment should always precede the employment of the pessary (when one is required) for a longer or shorter period, according to the peculiarities of each particular case.

2. The foregoing applies with equally cogent force to inflammations and prolapses of the ovaries, whenever these principles can be adjusted to such cases.

3. In abrasions, erosions, and ulcerations of the os, in the hyperplastic womb; in lacerations of the cervix; in subinvolution; in cystocele, in rectocele, and in all conditions of disturbed or impaired nutrition of the pelvic organs, it affords a most efficient form of either preparatory or curative treatment, tending to give the organs rest, restore their tone, deplete engorgement, remove blood stasis, improve locomotive power, and arrest retrograde tendencies in general.

4. In pelvic inflammations whether of cellular, peritoneal, tubal, or other origin or involvement, it will often change their current or arrest their progress; prevent suppuration or abridge its ravages; and thus frequently guide to a successful issue, without the necessity of a final appeal to a formidable and perhaps dangerous operation.—*Four. Am. Med. Ass'n*, Aug. 6, 1887.

On Incomplete Abortion in Twin Pregnancy.—The first case is narrated¹ by Dr. S. P. Warren, of Portland, Maine.

The patient was an VIII para of 35, whose first confinement had been with twins. At the third month of gestation she flooded badly for a day or so, and the blood continued to dribble for nearly a whole month.

¹ *Am. Jour. of Obstet.*, May, 1887.

During this time she had a painful lump in the right groin. An old woman poulticed her with Indian-meal and buttermilk for several days and the sore spot disappeared. Thinking she had miscarried, she looked carefully in the discharges for the baby, but saw nothing but "lumps of flesh." Six months later a ten-pound healthy child was born by a short easy labor, having the usual normal adnexa. Associated with the placenta was a fleshy mass, with the general characteristics of a placenta, but immature and degenerate.

The second case is reported¹ by Dr. V. M. Reichard. This patient was also an VIII para. Her last, a twin pregnancy, was aborted at the third month. On third or fourth month fetus had been extruded without pain or hemorrhage. "On examination I felt the sac of a second fœtus. The placenta of the discharged fœtus seemed to be beyond fœtus No. 1. She had no pain or hemorrhage, and I determined not to interfere. For two days her condition was unchanged. At that time the woman's family became alarmed, and a consultation was called. It was decided to clean out the uterine cavity. The gentleman called could not satisfy himself of the existence of the second fœtus. Accordingly, the membranes were ruptured and the fœtus discharged. The placenta was felt at the fundus, and neither before, during, nor upon examination after the removal, could any trace of the two placentas be found.

"In my mind, it was a case in which meddlesome midwifery was most emphatically bad, and it has always been a source of regret to me that I allowed my better judgment to be overruled."

Lefeur on Multiple Abortion Due to Lead Poisoning in the Father.—The wife of a plumber had not been pregnant in eighteen years. At this time her husband was treated for lead colic, and she became pregnant, but aborted at the third month. She became pregnant again, and aborted in a month and a half.

The husband, free from syphilitic taint, underwent treatment for lead poisoning, when his wife at once became pregnant, and was delivered at the eighth month, the child dying in five days in convulsions. The husband being treated anew, pregnancy occurred and went on to term. The

author says Constantin Paul has reported several similar cases.—*Rev. Méd.-Chir. des Mals. des Femmes*, July 25, 1887.

Drysdale (C. R.) on Multiple Still-Births in a Syphilitic Patient—Nine Dead Children.—Mrs. M., aged 37, in March, 1887, contracted syphilis when married in 1869, and had then sore throat and eruptions, which were pronounced to be syphilitic by her medical attendant. Her first child was born dead in 1870; her second, in 1872, at full term, also dead; the third, in 1873, at seven months, was dead; the fourth, in 1874, at nine months, was also dead; the fifth was an eight-months child, and was still-born; the sixth, a nine-months child, was still-born; the seventh was an eight-months child, and was still-born. Thereupon the patient began again to take iodide of potassium and sarsaparilla, and in 1882 she was delivered of a nine-months child, which had not exhibited any eruptions on the buttocks, snuffles, nor other symptoms of syphilis. The ninth child, born in 1883, was also dead, and the tenth, born in 1886, lived a month, and then died of inanition. This unfortunate patient, then, who had married at nineteen years of age, had actually had during seventeen years nine still-births and dead children due to the syphilitic poison she had acquired from her husband. The child born in 1882, and which accompanied its mother, was red-haired, and its teeth, first dentition, were much decayed, but was lively, and had no specific marks of hereditary syphilis.—*Med. Press*, June 29, 1887.

More-Madden (T.) on the Causes and Treatment of Barrenness.—According to the author the most frequent cause of sterility is stenosis of the cervical canal.

The method of treatment employed by him is the separation by cutting and simultaneous forcible expansion of the affected parts, followed by dilatation during the period of cicatrization, so as to prevent their subsequent contraction, and thus to secure the permanent patency of the previously occluded passage. To obtain this result he employs three instruments, namely: a special form of uterine director, which can, generally speaking, be introduced into any cervical canal, however narrow, and along which a serrated, triangular-guarded knife is made to travel up through the os internum; and, thirdly, a uterine dilator of great power, by which any required degree

¹ *Am. Jour. of Obstet.*, Aug., 1887.

of cervical expansion may be effectually secured and accurately gauged.

He regards stenosis, as well as occlusion of the fallopian tubes by salpingitis and its results, such as hydro- and pyo-salpinx, as far more common causes of sterility than is generally recognized. Moreover, he also holds that such tubal diseases may, in many instances, be efficiently dealt with, without resort to the serious operative procedures, by less heroic measures, as aspiration and catheterization of the tubes.—*Med. News*, Sept. 10, 1887.

Braithwaite (J.) on a Method of Treating Some Cases of Scanty Menstruation and of Amenorrhœa.—Many years ago, reflecting upon the hemorrhage caused by intra-uterine polypi, I introduced into the uterus, when I wished to bring on menstruation or to increase its amount, small foreign bodies, which were left in its cavity. At the same time other means of treatment were not neglected, such as the use of hot baths, the administration of iron, aloetic aperients, and alteration in the diet and habits of patients when luxury and indolence appeared to be at the root of the matter, as they sometimes are. The most convenient foreign body is a piece of hempen ligature, doubled several times, knotted, and impregnated with pitch. These were easily passed up to the fundus without any preliminary dilatation, and left there. Some success resulted from their use; but the uterus generally expelled them before they had done their work, and I therefore abandoned them for a Greenhalgh's rubber stem. This is very efficient, and I have by means of it been able to do every thing needful in a considerable number of cases. The stem, carefully washed in carbolized water, should be introduced and left in position a week before menstruation is due, or supposed to be due. Usually a hemorrhage will result within a few days; but the stem should remain *in situ*, whether it comes on or not.—*Br. Med. Jour.*, April 30, 1887.

Potter (F. W.) on Uterine Hemorrhage of Probable Malarial Origin.—Regularly every two weeks, beginning about 3 o'clock, in a woman, the mother of three children, hemorrhages came on, and, strange to say, could not be arrested by ergot, opium, elixir vitriol internally, nor by sugar-of-lead and alum injections. Rest in bed was prescribed and quinine given, but not with the desired result, until the dose was increased to 40 grains every

twenty-four hours, beginning to administer it five days before expected paroxysm, with complete arrest of pain and hemorrhage.—*North Carolina Med. Jour.*, May, 1887.

Davenport (F. H.) on Uterine Hemorrhage.—The most commonly used internal remedies are ergot, gallic acid, hamamelis, hydrastis canadensis, and iron.

With ergot I have been disappointed, except in a few cases of fibroid during the time when the tumor seemed to be growing toward the interior; that is, changing from the interstitial to the submucous variety. When it had once got within the cavity and had become pedunculated, the ergot seemed to lose its effect. It has also proven of use in cases of subinvolution; but where the trouble is seated in the mucous membrane, as in cases of hyperplastic endometritis, for example, I have usually seen very little benefit, as regards the hemorrhage, from its use.

Hamamelis alone, or with equal parts of ergot, I have also frequently given, but have been disappointed with the result. The mixture is exceedingly disagreeable to take, and has very little effect on the hemorrhage.

With gallic acid I have been better pleased. Five or ten grains given in a wafer every three or four hours has often checked the flow, especially in cases where there is a great deal of passive congestion, from some misplacement or inflammatory condition about the uterus.

A good deal has been written lately in favor of hydrastis, and, especially in Germany, surprisingly good results have been claimed in cases of menorrhagia due to endometritis and other pathological conditions of the lining membrane of the uterus. I have tried it only in one case, and then with no apparent benefit. It deserves a more thorough trial.

I have alluded to iron in speaking of atony of the uterus, and have often found it of great value in young women whose only complaint is excessive menstruation, and in that rare class of cases, chlorosis with menorrhagia. The tonic effect of the iron seems to be all they need.—*Bost. Med. and Surg. Jour.*, Aug. 18, 1887.

Janvrin (J. E.) on a Case of Tubal Pregnancy, and Remarks on the Treatment of Such Cases.—The history was one of a case of tubal pregnancy, occurring, as the first pregnancy, in a married woman who had been sterile for some

seven years, in which conception could not have begun until the 21st of April, furnishing all of the symptoms of such a pregnancy, viz., the frequent and slight hemorrhages, probable discharge of the decidua, the usual changes in the appearance of the breasts—which latter symptom I have always noticed before the second month, and in three cases before the expiration of the first month,—the *intense* tenderness of the tube when pressure is made upon it,—in fact, all the symptoms, excepting the colicky pains, as early as the 25th of May; fully diagnosed as such on the 2d of June (although no colicky pains occurred until the 9th), the first attack of which pains was undoubtedly caused by the slight hemorrhage from the small branch of the artery.

Following this comes the profound shock, with its accompanying train of symptoms, a mild inflammation over the surface from which the hemorrhage had taken place, which had fully subsided within six days. Then the use of galvanism applied by an expert on three successive days, and eighteen hours after the last application, when the foetus was dead, comes the secondary and fatal hemorrhage from the branch of the artery, bringing the case to an unexpected termination within eight (possibly seven) weeks of the time of conception.

The author submits the following as embodying his own ideas as to the proper treatment to be resorted to in certain cases of undoubted tubal pregnancy: That in cases where a moderate hemorrhage has been positively diagnosed (whether from a rupture of a superficial artery or a venous plexus, or from a partial rupture of the sac itself), and from this hemorrhage has occurred prior to the termination of the fourth month of gestation, it is undoubtedly better surgery to perform laparotomy at once, and thus remove all possible danger of further hemorrhage, than to trust to electricity in any form. Cases of this kind, in which a positive diagnosis can be made, have been rare up to the present time; principally, I think, from the fact that the full significance of the so-called "colicky pains," with the shock and collapse, has hardly been appreciated. I am convinced that in these attacks there is always some bleeding, it may be very slight, from the superficial vessels of the sac; and that, as a rule, several (three or four) attacks occur before the real rupture of the sac takes place. If I am right in this, it seems to me that in all such cases,

where the symptoms of hemorrhage are becoming at all alarming, we should at once resort to laparotomy. In all cases in which hemorrhage has been considerable there will, as a rule, be a decided tear in the sac, and in such cases it seems to me that laparotomy is generally demanded as soon as the patient rallies from the shock sufficiently to have a fair prospect of recovery from the operation.—*Gynaecol. Trans.*, vol. xi., 1886.

Fales (W. H.) on a Case of Extra-Uterine Pregnancy the Foetus being Retained for Thirty Years and Becoming a Lithopædion.—Mrs. A. was married in 1844; first child four years later; second pregnancy eight years later; probable rupture of tube and subsequent attack of peritonitis at third month; death of foetus at ninth month; death of Mrs. A. from cancer of the larynx thirty years later.

The autopsy was performed September 26th, Drs. Bill and Metcalf assisting.

The body was very much emaciated. The tumor was apparently situated about in the median line, but on palpation was found to extend downwards and to the left, the contained foetus occupying a sacrum-left-anterior position, but entirely out of the pelvic cavity, the base of the skull being on a level with the umbilicus. On making the incision the tumor was found to be adherent to the abdominal wall, and it seemed as though it would soon have made its way through, either by pressure or ulceration, so thin had the structures become at the point of its adherence.

It was almost lying loose in the abdominal cavity, the only points of attachment being the one just referred to, the pedicle, and some small adhesions to the intestines.

The intestines were ranged around the tumor—none in front of it,—and were one mass of adhesions, forming with the abdominal walls the sac, as it were, containing the tumor.

The pedicle passed directly downwards, enclosing the uterus and then fading out gradually into the peritoneum. Nothing that would answer for a placenta, or the remains of one, could be found.

The autopsy suggested an extra-uterine pregnancy of the abdominal variety, but the history points rather to a ruptured tubal becoming an abdominal.—*Bost. Med. and Surg. Jour.*, Aug. 11, 1887.

Mundé (P. F.) on Three Cases of Pregnancy Complicated by Ovarian

Tumors—Ovariectomy—Recovery.

Three cases of pregnancy complicated by ovarian tumors were narrated, illustrating several phases of this rare combination, the first being an instance of ovariectomy during pregnancy, with preservation of the fœtus till term, and recovery of the mother; the second, the induction of premature labor, with the delivery of a living and still living child, and the early subsequent removal of the tumor, with recovery; the third, successful removal of the ovarian tumors, but interruption of gestation in consequence. So far as the chances of recovery from ovariectomy during pregnancy are concerned, they are fully as good as when no pregnancy exists. As regards the continuance of gestation, in the early months usually the prospect is also favorable. In the later months, when the child is viable and likely to survive, the induction of premature labor would appear to be preferable, with subsequent ovariectomy. When the operation is not urgent, it is well to defer it until the child has attained viability, in case the operation should bring on labor. The greater difficulty of the operation, and the increased danger from septic infection and uterine hemorrhage at a later period of gestation, must also be borne in mind in deciding the question whether it is wise to postpone the operation. For, after all, the mother's life is always the chief consideration. Tapping the cyst is not to be advised, even as a means of temporary benefit, except in cases where immediate relief from distension is called for, and ovariectomy cannot at once be performed.—*N. Y. Med. Jour.*, Aug. 6, 1887.

Winslow (J.) on a Novel Treatment of Placenta Prævia.—Summoned in haste one night to a stout German primipara, I was at her bedside in less than five minutes after the messenger had left it. The blood had already saturated the bed, made a pool under it, and flowed across the room. It was still pouring from the vagina, when, introducing the whole hand, I found the os about the size of a half dollar, with the presenting placenta so firmly adherent all around that it could nowhere be detached, and too thick and firm to be penetrated by the finger. To check the hemorrhage, I closely applied the palm over the os (with the fingers in the posterior cul-de-sac, as the patient lay supine), while the external hand over the fœtal breech strongly held the head against the placenta,

the lowest part of which was thus firmly compressed. Hemorrhage was impossible, and not another ounce of blood was lost until, after four fatiguing hours of this steady pressure, the os had so far dilated as to allow one edge of the placenta to slip out, forced down by the head, which now of itself compressed the attached portion against the pelvic wall. Delivery was spontaneous and speedy; and the large, thick after-birth showed near its centre a circle some four inches in diameter much thinned and completely blanched. Both mother and child did well.—*N. Y. Med. Record*, July 30, 1887.

PATHOLOGY.

Stuart (F. W.). Can Cirrhosis Follow Trauma?—A Case of Medico-Legal Interest.—October 3, 1885, during the service of Dr. E. O. Otis, J. B., aged ten years, came to the Carney Hospital. His family history was good. He had always been well up to 1882, when he had an abscess on the left side of his neck, which suppurated for two years, and resulted in contraction of the left side of the neck. He had visited the Carney Hospital in June, 1885, when the following note was made: "Patient listless, loss of appetite, diarrhœa three days; contraction of sternomastoid on the left side due to an old abscess, tenderness over the site of the old gland and in the region of the pneumogastrie." The patient complained only of swelling of his abdomen. He was very irritable, and cried so much that it was impossible to make a careful physical examination, though it was evident that there was fluid in the peritoneal cavity, fluctuation being well marked. He was given syrup. ferri iodidi, and told to return the next day for a careful examination.

The patient returned Monday, October 5th, Drs. E. O. Otis, W. H. Devine, and myself being present. We were now told that on Tuesday, September 29th, while playing in the street he became involved in a disturbance with a schoolmate, and, though an exact story of the quarrel could not be obtained, it was established that the patient had been knocked down, and while lying on his back had been stamped upon, the heel of the assailant striking him in the abdomen. The patient spat up some blood, walked into his house not far away, com-

plained of some pain, but the next day was able to attend school. On the Saturday following, his mother first noticed that his abdomen was swollen; and brought him to the hospital.

Physical examination showed the patient to be well developed for a boy ten years old, but he was decidedly pale and cachectic in appearance. His temperature was normal, and his pulse and respiration were but little hurried. Heart and lungs were normal. His abdomen was much enlarged and fluctuating. On percussion there was dulness everywhere, with some areas of flatness, and the percussion note was unaffected by a change in the patient's position. The urine was high-colored, specific gravity 1021, albumen one eighth per cent., and the sediment contained some renal epithelium, urates, and a few casts. The existence of an exudation was, of course, very evident, and a diagnosis of chronic peritonitis was easily made, but at the same time it was felt that there must be something underlying the peritonitis.

In a few days the distension became more marked, the genitals were very oedematous, and the breathing became embarrassed. On October 16th, the abdomen was aspirated, and about two quarts of a clear serous fluid were drawn off, it being impossible to aspirate more than a small part of the exudation, owing to its being sacculated. At the same time the genitals were punctured with a needle and the fluid allowed to trickle away. During this time the patient bled very frequently from his gums. Under symptomatic treatment the effusion largely disappeared, and the patient was able to attend school again. This improved condition lasted for some time, after which the fluid began to re-accumulate, and a scrotal hernia was developed on the left side.

Again there was improvement, and in May, 1886, the patient returned to the hospital to see if something could not be done for his neck.

Examination at that time showed still evidences of the exudation, and the borders of the liver and of the spleen were undeterminable.

July 25th, Dr. Devine was called to see the patient, and afterwards Dr. Otis saw the case with him. The patient then had great distension of the abdomen, and general oedema. Tapping was advised, but not consented to by the parents.

August 5th, the patient complained of great pain in his abdomen, his pulse was rapid, temperature high, and the general constitutional disturbance great. Dr. Devine, who was then attending the patient, attributed these symptoms to an acute exacerbation of the peritonitis. The patient died August 6th, and autopsy was made by Dr. F. W. Draper, medical examiner, at 2.45 P.M., August 6, 1886.

Body very pale; a little livid discoloration of the dependent parts.

Rigor mortis absent.

No appearances of decomposition.

General anasarca—oedema of face, arms, hands, thorax, abdomen, genitals, legs; and feet.

Abdomen distended with fluid; fluctuation well marked.

Scrotum large and red. At the left inguinal ring, there was an opening sufficiently large to admit the index finger easily.

Internal examination: The peritoneal cavity contained one hundred and seventy-two fluid ounces of clean, thin, serous fluid.

The heart was normal.

The lungs were oedematous and injected in their lower and posterior portions.

The spleen was enlarged to four times its normal volume; it was softened, and its section presented limited areas of diffuse hemorrhagic infiltration.

The kidneys were moderately enlarged, pale, with normal relations between the cortical and medullary portions; their capsules were free.

The liver was reduced to the size of a man's fist; it was of very dense consistency, light-yellow color, with thick interstitial partitions between the lobules, and a great number of small nodules upon its surface.

The intestines and apposing surfaces of the abdominal organs were firmly adherent at numerous points by strong bands, representing a former inflammation of the peritoneum; and layers of soft lymph at various situations indicated more recent peritonitis. The peritoneum was thickened and opaque. There was no purulent exudation. The peritoneum and mesentery were oedematous and the dependent parts of the intestinal folds showed limited patches of hemorrhagic infiltration.

The stomach and intestines presented nothing remarkable upon internal examination.

The mesenteric glands were normal.

The brain was soft and œdematous.

Diagnosis : Chronic interstitial hepatitis ; chronic hyperplasia of the spleen ; chronic adhesive peritonitis ; ascites and general anasarca.

What caused the cirrhosis of the liver in our patient ? Did the trauma cause it ?

There was no history of the abuse of alcohol ; there was no question of syphilis, since parents and brothers and sisters were all healthy and free from any signs of this disease, and the patient had never had intermittent fever. If the injury caused the disease, it first started up a chronic peritonitis, and secondary to this came the cirrhosis. That such a thing is possible has been suggested, but I think it hardly probable, and in this case I feel that in June, 1885, when the patient was listless, etc., and a diagnosis of indigestion was made, he had beginning cirrhosis.—*Bost. Med. and Surg. Jour.*, July 28, 1887.

Canedy (F. L.) on Grinder's Consumption.—There have been employed in the grinding-room of the Lamson & Goodnow Cutlery Company, at Shelburne Falls, from thirty to fifty men and boys, for the past twenty-five years, giving an average of about forty.

During the past ten years there have died with chronic disease of the air passages twenty-three of these grinders. Seven Irish, seven English, six American, and three Germans, of which five were between sixty and seventy years of age, eight between fifty and sixty, three between forty and fifty, five between thirty and forty, and two between twenty and thirty, and there are now sick, confined to the house, three, one English, between sixty and seventy, and two Germans, one fifty-five years old, and another about thirty-five. There are still grinding five, in whom the disease is known to have made considerable progress.

This amount of fatal disease of respiratory organs in such a limited number of men, the majority of them considerably past the age at which consumption is most common, points positively to their occupation as a predisposing, if not an exciting cause, of no small importance, and my experience among these cases for the past ten or fifteen years, in the sick-room and by the post-mortem table, has convinced me that the name of "grinder's consumption," given the disease by the laity, is a proper one.

That we all inhale no inconsiderable amount of dust in respiration is well known, and that certain occupations, as mining, wood and metal polishing, etc., cause the workers to inhale an atmosphere so loaded with dust of an irritating character as to produce specific lesions of the bronchial tubes and lungs, has become so well established, that all the newer books upon diseases of the respiratory organs treat of this condition under the somewhat hard name of *pneumonokoniosis*, a classification of which is based upon the nature of the dust inhaled. Of all these forms, none seem more certain or fatal in its effects, than the grinder's ; Peabody, in some investigations made at Sheffield, England, making the average period they are able to continue their work thirteen years.

The morbid anatomy of grinder's consumption, as I have studied it in three post-mortem examinations, I have found as follows : The bronchial lesions are those of chronic bronchitis, with thickening of the bronchial mucous membrane, associated with ulceration and bronchial dilation, forming bronchiectatic cavities. These cavities, which are a marked feature in some cases, are said to be caused by a combined softening of the bronchial tissues, with traction from without by the newly-formed fibrous tissue.

The treatment of these cases is in no wise peculiar, being similar to that of fibroid phthisis from other causes.—*Bost. Med. and Surg. Jour.*, Sept. 1, 1887.

Robertson (A.) on Pyo-Pneumothorax Caused by Rupture of Lung from Strain upon Old Pleuritic Adhesion.—The patient was a man of twenty-one with a brief phthisical history. Quite suddenly great distress of breathing occurred, and examination revealed the usual signs of pneumothorax. The axillary temperature was 140°, and the fever heat continued high on successive days. Three days later the indications of fluid in the pleural cavity were clear, and it being considered that the fluid was probably of a purulent nature, a large amount of pus was withdrawn, the pleural cavity was washed out with solution of perchloride of mercury (1:5000), and a drainage-tube afterwards introduced ; considerable relief was obtained at the time, but the secretion of pus continued in large quantities, notwithstanding the drainage and the injection of the perchloride solution every second or

third day. The patient gradually became weaker, and died.

The condition revealed by the post-mortem examination was as follows: The left lung was firmly adherent throughout, and its apex was consolidated and contained numerous caseous masses and small irregular cavities. The right lung was free, except at a point corresponding to the fourth rib, about four inches from the costal cartilage; there it was firmly adherent to the chest wall over an area of about a square inch. Immediately below this adhesion there was a small opening in the lung, through which air passed into the right pleura. The lung was collapsed, and the pleural surfaces were greatly thickened, and covered with purulent membrane. There was no consolidation or other organic disease of the lung. The left pleural cavity contained about twenty ounces of pus. The pneumothorax in this case was doubtless caused by a rupture of the lung, resulting from a strain upon the firm but localized pleuritic adhesion.—*Glasgow Med. Jour.*, August, 1887.

Baré on Perineo-Anal Zona in Tuberculosis.—Zona must be classed as a rare complication of phthisis. Generally it is seated on the thorax, but it appears also in other localities, as the face, neck, loins, limbs, and perineo-genital region. The eruption is sometimes accompanied by motor disturbances, temperature changes, and vaso-motor perturbations of a reflex nature. It has its origin in a tubercular meningo-myelitis or a parenchymatous peripheral neuritis.—*Gaz. des Hôp.*, May 17, 1887.

Gnezda (J.) on the Poison of Cholera.—The poison has been brought from India by Dr. Robert Koch, in a dried form. It is soluble in water, not soluble in ether or alcohol. It is precipitated by hydrochloric acid and other agents. The poison is a chemical substance, but it is uncertain whether it is an alkaloid, a ptomanic, or some other substance; perhaps a ferment. It causes alterations of the red-blood corpuscles and chocolate-colored blood. Characteristic spectroscopic appearances are also found. No antidote will be likely to be found until the character of the poison is more precisely determined.—*Med. Register*, Sept. 9, 1887.

Signal on the Action of the Micro-Organisms of the Mouth and Fæces upon Some Alimentary Sub-

stances.—The author has studied the effect of nineteen different micro-organisms, found in the mouth, upon different foods, and concludes, with M. Pasteur, that they play a very important part in the rôle of digestion. He estimates that there are more than 20,000,000 micro-organisms in a decigramme (gr. 1/10) of healthy fæcal matter.—*Le Cour. Méd.*, Aug. 20, 1887.

Davidson (P.) on Calculi in Both Ureters Causing Cystic Atrophy of the Kidneys—Death from Uræmia.—A boy, H. B., aged ten years, was admitted into Infirmary for Children, November 1, 1886, under Dr. P. Davidson. The patient had scarlet-fever several years ago, followed by some dropsy. One year before admission he had retention of urine for two days, after which he passed gravel for some days in his urine.

On admission he complained of thirst, nausea, sleepiness. No pain felt on palpating abdomen.

During the next few days he passed a large quantity of pale urine of sp. gr. 1008, neutral in reaction, and depositing a small amount of mucus. It showed a trace of albumen with the cold nitric acid test, and under the microscope presented granular tube casts and crystals of oxalate of lime. It contained on an average 300 grains of solid matter, and 150 grains of urea per twenty-four hours.

On November 12th symptoms of uræmia developed themselves, and the patient died in convulsions.

Post-mortem twenty-eight hours after death showed adhesions of pericardium, thickening of mitral valve, adhesion of right lung.

Left Kidney.—With the exception of a small piece of kidney, structure at upper end was simply a sac containing urine.

Right Kidney.—Pelvis and calices much dilated, but a considerable portion of kidney structure still remaining.

Both ureters thickened and dilated; diameters varying from a quarter of an inch to half an inch.

At about one inch from the lower end of the left ureter, a calculus was found of about the size and shape of an olive. It was hard, smooth, and greenish-black in color. It was movable above a certain point in the ureter.

A similar calculus was found in a similar position in the right ureter. It also was movable above a certain point.

Below the sites of the calculi both ureters narrowed to their normal sizes before entering the bladder.—*Liverpool Med. Chir. Jour.*, July, 1887.

Hughes (A. W.) on the Etiology of Varicose Veins, with Notes of Dissections.—The causes of varicose veins have been differently explained by various writers, such as the effects of gravity, the passage of veins through constricted openings in fascia, debility, pregnancy, the pressure of tumors, and a host of other causes.

During the past two years I have dissected four subjects, where there were well-marked varicose veins, and certain points which I noticed seem to me to offer a more satisfactory explanation than those usually mentioned.

1. In all cases the internal or long saphenous vein was varicose.

2. The only portion of the short saphenous vein which was varicose was that part which lies in the popliteal space after it has pierced the deep fascia.

This part of the vein was distinctly varicose in each, and in one it was enormously dilated and sacculated, while the rest of the vein was normal. In these I could find no trace of valves at the point where the saphenous vein enters the popliteal.

3. The deep veins were not affected in any of the cases.

In one other subject I have noticed a well-marked varicose condition of the popliteal vein, while the rest of the deep veins were normal.

One of the most important factors in carrying on the venous circulation is compression during muscular contraction, and this affects most forcibly the deep veins, which are mostly surrounded by muscles, while we find that the circulation in those veins which are not supported by muscles, such as the superficial veins, the hemorrhoidal and spermatic veins, always tends to be sluggish, and often results in varicosity.

Now, in walking and standing, the contraction of the muscles compresses the deep veins, and the amount of blood passing through the superficial veins is increased, and, in consequence, these veins tend to become dilated.

This affects more especially the long saphenous vein, which lies between skin and bone, in a great part of its course, being thus unsupported by muscles, but this

determination of blood to the superficial veins does not cause a dilation of the short saphenous vein, because the contraction of the muscles of the calf compresses it against the skin, which is rendered tense by the thickening of the limb caused by the contraction of the muscles; but that part of the short saphenous which lies in the popliteal space does tend to become dilated, as it is not supported by the contracting muscles; in fact, as regards muscular support, its position is comparable to that of the long saphenous vein, thus explaining the fact of its being varicose in this part, and healthy in the rest of its course.

One often notices that during pregnancy a varicose condition of the superficial veins of the lower extremity appears rather suddenly, and this condition appears usually in two distinct and fairly constant positions: one being in the popliteal space, where the short saphenous becomes much dilated and tortuous, which is explained by want of support; the other position being just above the ankle, in the course of the long saphenous vein, the predisposing causes here being want of support, together with a curve that exists in the vein in the region of the internal malleolus, the blood from the foot meeting at this point with the pressure of a vertical column of blood in the vein beyond.

I am aware that a varicose condition is sometimes seen extending along the whole course of the short saphenous vein; but what I maintain is, that in a large proportion of cases the dilatation commences above in the short saphenous, but below in the long saphenous vein, conditions which I think are satisfactorily explained by the points mentioned above.—*Br. Med. Jour.*, July 16, 1887.

Three Unusual Cases of Suicide.¹—Dr. G. G. Hubbard, of Hornellsville, N.Y., reports² a case of triple suicidal injury.

C. C., aged twenty-nine, a farmer, prosperous, with pleasant environment, was found dead by his wife in his barn, lying on his back on the floor. His own revolver lay within reach of his right hand. It was a twenty-two calibre, five-barrelled revolver; three chambers of it contained empty shells, the others were loaded. There were three bullet-wounds on his body; two of them were in the cardiac region, and the

¹ See MEDICAL ANALECTIC, Sept., 1887, p. 427.

² *N. Y. Med. Jour.*, Aug. 20, 1887.

clothing surrounding them was scorched and powder-burnt, indicating a very short range. The autopsy showed that one of the bullets had entered the cavity of the right ventricle of the heart; the other one had not touched the heart. The third bullet had entered the right temple and penetrated the brain at least four inches. This one had evidently been shot last, and the wound was also powder-burnt. The wife of Mr. C. testified at the inquest that she was awakened at five A.M. by her husband vomiting. He arose and went into the pantry (where he kept his pistol), to get some peppermint, he said. He then went out of the house and she fell asleep again, and awoke in an hour, and went out to hunt him up, as he had not returned, and found him dead in the barn. All the evidence pointed to suicide, and the jury brought a verdict to that effect.

S. W. North reports¹ a case of double suicidal injury.

A. B., aged forty-seven, a respectable mechanic, had for more than a week shown symptoms of mental disturbance. A fellow-workman said that he was depressed, and had delusions of persecution; that, though a good workman, he had for some days spoiled his work; he had, however, kept to his work up to the night before his death.

Soon after six o'clock on the morning of July 2d his wife found that he had got up and left the room. She called him by name, when he answered from the sitting-room below. On going down stairs he passed her on the staircase on his way back to the bedroom, having no clothing on except his shirt. Very soon after this, hearing him groan, she went upstairs, and found him lying on the bed covered with blood, either dead or nearly so.

I saw him soon after this. He was lying on his back on the bed, with his legs hanging over the side and touching the floor, the whole of the front of his body covered with blood. There was much blood on the floor, leading to the conclusion that the injury had been inflicted whilst standing near the bed. A razor with the blade tied into the handle was found on the bed near his neck.

There was an extensive wound in his throat, extending from left to right and from above downwards, dividing all the vessels on the left side and the trachea

down to the spine. Just below the nipple on the left side there was a wound two inches in length, dividing the costal pleura the whole length. On pressing the finger into the cavity of the chest the lung could be felt collapsed, but no wound of either heart or lung could be discovered. No *post-mortem* examination.

Both wounds—namely, that on the neck and that on the chest—were clean incised wounds, without the least jagging, looking as though they had both been made with a very sharp instrument, and by a determined hand.

The point of interest in this case is the double injury, the wound in the chest having in all probability been inflicted from some popular notion that wounds of the heart were rapidly fatal. Finding this not so, the more effectual wound in the throat was inflicted. Such a case, in the absence of evidence to the contrary, might possibly lead to suspicion of homicide.

Dr. Hubbard² asks:

"Can a man shoot himself in the uncovered face with a pistol held in his hand without having the bullet-wound powder-burnt?" A case bearing upon this query occurred recently in this vicinity:

T. M., a man with domestic troubles that made life a burden, was seen late one night, in the outskirts of the town, flourishing a revolver. He sat down under some bushes. A few minutes afterwards a pistol-shot was heard, and the man was found with a bullet-hole in the centre of the forehead. The bullet penetrated the brain in a direction slightly downward and to the left, and it was found lying against the occipital bone. The wound was not powder-marked in the least, nor could any powder be discovered within the wound after the most careful search. The four charges remaining in the revolver, when found, were fired at targets covered with white chamois-skin, at distances of three, eight, eighteen, and thirty inches, respectively, and in every case the skin surrounding the bullet-hole was powder-burnt. All the other evidence indicated suicide. The jury at the inquest disagreed. Those who dissented from a verdict of suicide did so entirely on account of the absence of powder-marks around the wound, holding to the opinion that that was conclusive that the man had not shot himself.

¹ *Brit. Med. Jour.*, July 23, 1887.

² *L. c.*

Frew (W.) on a Case of Diabetes Mellitus in a Girl of Nine Years, with Hereditary History.—The patient, a child of nine, began to lose flesh, eat and drink excessively, and have polyuria. She had a cachectic look. Her urine was sp. gr. 1037, and contained a great deal of sugar.

The child's grandfather, uncle, and aunt, on father's side, all died from diabetes.

The patient developed double cataract; she was operated on for one a short time before death.—*Glasgow Med. Jour.*, April, 1887.

ORTHOPÆDIC SURGERY.

ABSTRACTS AND SELECTIONS BY JOHN
RIDLON, M.D.

Shaffer (N. M.) and Lovett (R. W.) on the Ultimate Results of the Mechanical Treatment of Hip-Joint Disease.—An analysis of fifty-one cases occurring in the service of the New York Orthopædic Dispensary and Hospital.

The cases upon which the report was made were drawn from the dispensary class only; private cases and those from hospital or other sources, as well as those in which excisions had been performed were eliminated from the list.

In order to arrive at positive and *ultimate* results, the following bases of investigation were formulated:

I. No case was to be considered which had not been under the care of the institution from the time of its entry to its final discharge.

II. No case was to be considered which had not been formally entered as "discharged cured" after a final examination.

III. No case was to be considered which had not been "discharged cured" at least four years prior to the investigation.

IV. No case was to be considered except those which presented unmistakable signs of the disease at the time of the first examination.

V. None were to be considered which had not been at least two years under treatment.

VI. None were to be considered which were not seen or examined after the investigation was commenced.

VII. All cases coming within these ex-

clusive conditions were to be classified and reported.

The general plan of treatment may be briefly described.

In each case reported, a long Taylor traction-splint was applied soon after the first examination, and the parents or some friends of the patient were instructed in the use of the apparatus. The patient, unless recumbency was necessary to overcome a malposition of the limb, or unless the symptoms were so acute as to demand rest (in which case the patient was visited at home by the out-door visiting surgeon), was allowed almost unlimited exercise in the open air. He was instructed to call at the dispensary every week or two for observation and re-adjustment of the apparatus, etc. If the patient's condition required recumbency for a month or more, and his home was inadequate, he was placed in one of the wards of the institution, but was removed and placed in the dispensary service again as soon as walking was practicable.

The aims of treatment were:

1. To overcome by mechanical means any acquired deformity that existed before treatment was commenced.

2. To protect the diseased joint from traumatism.

3. To permit the patient to have unrestricted out-door exercise, and

4. To maintain that position of the limb which would reduce deformity to the minimum if ankylosis occurred.

In no case was any operative measure employed, except the occasional opening of an abscess. "Cold abscesses" were allowed to take their own course, unless they were in a location which interfered with the use of joint protection. Little or no medication was employed.

Of the fifty-one patients traced, four had died,—two of meningitis, probably tubercular, one four months, the other six years after discharge, and two of pneumonia, seven and ten years, respectively, after discharge, having been in robust health up to the time of their last illness. Six had relapses. They had been under treatment two and a half, four, four, four, five, and seven years, respectively. One of these remained well two years; two were well three years, two four years, and one five years, before relapse occurred. The remaining forty-one patients were seen at their homes and carefully examined, with

the exception of two, who were reported to be in excellent health, and walking well at the end of four and six years, respectively. The remaining thirty-nine patients were under treatment from two to eight years; the disease had existed prior to the commencement of treatment from two weeks to nine years; twenty-seven had one or more abscesses at some stage of the disease, and twelve had none. But the latter were by no means the less marked cases or the ones followed by the best results. The difference in the length of the limbs was from none (two cases) to two and a half inches, with two exceptions. One patient with dislocation of the head of the femur, but without any evidence of suppuration, had six inches' shortening, and one (also without abscesses) had three inches; while one of the children with no shortening had six distinct sinuses, and the other two. Eighteen cases cured before ten years of age represent an aggregate of twenty-five inches' shortening, while nineteen cured after ten represent thirty-eight inches' shortening. The difference in the length of the legs almost always slightly increases after the disease is cured.

Nineteen cases were found with practically ankylosed joints, six with slight motion in flexion from 10° to 45° , and a certain amount of motion in other directions; three with motion to a right angle in flexion, and good rotation and abduction; and three were found with perfectly free motion in every direction. Examination proved that the amount of motion grows less as time goes by.

In fifteen of the cases where there was little or no motion at the articulation there was no flexion of the thigh. The limp in these cases was trivial. In other cases the thigh was flexed at an angle of 120° to 135° with the horizontal plane of the body.

Permanent *adduction* is a more important matter. Of twenty-four cases, it was very slight or absent in thirteen, in eight it equalled 10° to 15° , and in three cases it was about 30° . Adduction is likely to occur after the removal of the splint, and to increase up to a certain point.

Pain and weakness of the ankle of the affected side was common, and an inability to flex the foot beyond a right angle was present in twenty cases and absent in thirteen.

Habitual malposition of the spine in standing, walking, or even in sitting, was present in many cases. And yet in only

one case was there any thing that approached true lateral curvature.

Only one, a boy who had suffered from both Potts' disease and hip-disease, used a cane, and none used crutches. There are among those who recovered, printers, glaziers, machinists, errand-boys, shop-girls, dressmakers, and many children attending the public schools,—all at their work, and none with evidences of active tubercular disease or any serious incapacity arising from the condition for which they were treated years before.

In the discussion which followed, Dr. Lovett, who did the work of measuring and otherwise examining the patients at their homes, said that he found them to be exceptionally healthy people, having recovered from their hip-disease. Only a few wore high-soled shoes on the affected side. Dr. Ridlon said that it had been assumed that all these cases were tubercular, but he believed that there were cases due to traumatism and to inherited syphilis, and that these should modify the treatment. Dr. L. A. Sayre said that in some cases the peculiar constitution of the patient prevented the disease yielding to this mode of treatment. If under local and constitutional treatment the case did not progress favorably, he would not allow it to go on for six or eight years, but would perform exsection and remove the dead bone. Dr. A. B. Judson believes that if the patient can be induced to restore the natural rhythm of the gait, and to divide the time spent on the ground equally between the two feet, he will gradually substitute abduction for adduction. In closing, Dr. Shaffer said that he had been unable to differentiate between tubercular and syphilitic cases, except that in some instances the patients recovered under the influence of what was known as anti-syphilitic treatment.—*N. Y. Med. Jour.*, May 21, 1887.

Taylor (H. M.) on Diagnosis of Incipient Hip-Disease.—A little girl æ. four years, limped, complained of being tired, and wanted to be carried whenever she took a long walk. Examination revealed nothing but limited motion in one direction—adduction. The interest in the case is that this condition persisted for eighteen months without any other manifestations of hip-disease. After this, however, other symptoms appeared, and the diagnosis was conclusive.—*Practice*, April 15, 1887.

Steele (A. J.) on the Early Recognition of Hip-Disease.—The symptoms are as follows (not, however, in the order necessarily in which they present themselves) :

1. Limp. It is perhaps neither severe nor constant, but more marked in the morning on rising and gradually wearing away during the day.

2. Pain. Sometimes slight and sometimes very severe. It is usually referred to the inner side of the knee ; and is liable to exacerbations. Later on a paroxysm of pain occurring at night is symptomatic of bone lesion, and called the osteitic cry.

3. Altered position. Very early the limb is slightly flexed, a little later abducted and rotated outwards.

4. Loss of motion in the joint.

5. Wasting of the limb and flabbiness of the muscles. Flatness of the natis is not of much significance.

6. Swelling, when present, may be recognized in front of the capsule or behind the trochanter, or by a brawny thickening about the joint.

7. Sensitiveness of the joint.

Not all these symptoms may equally be present ; one or more may be strongly marked and others in abeyance.—*St. Louis Cour. Med.*, July, 1887.

Macnamara (C.) on Acute Osteitis of the Neck and Head of the Femur.

—Acute inflammation of the neck and head of the femur, occurring in young people, is not infrequently met with, the severity of the disease varying under conditions which are but little understood. Osteitis in this locality, however, is always alarming, as it may lead to suppurative inflammation of the bone and synovial membrane, and so to dangerous septicæmia. In the majority of these cases the symptoms are preceded by an injury to the joint in a child or young person ; the soft and growing tissues at the junction of the neck with the epiphyseal disc of the cartilage of the head of the bone are bruised, and there seems reason to believe that in the injured tissues a specific micro-organism finds a congenial soil in which to grow ; rapid suppuration follows, with its attendant evils. In these cases, therefore, we have not only to deal with the suppurative synovitis of the hip-joint, but also with an acutely inflamed portion of bone, and it is this complication which renders these cases so difficult to treat with success.

The joint can be drained without trouble, but I have failed as yet, in disease of this kind, to efficiently drain the head and neck of the femur.—*Brit. Med. Jour.*, July 2, 1887.

Whitman (R.). A Report of Four Cases of Excision of the Hip Performed in 1882.—The patients were between the ages of four and ten years ; had had symptoms of hip disease from six months to three and a half years ; and all had abscesses. Excision was performed, all the diseased bone in the femur removed, and the acetabulum scraped out, and the wounds dressed antiseptically. In the first three cases sinuses remained until the patients died : the first at three months, of meningitis ; the second, of shock, at thirty-six hours ; and the third, of amyloid degeneration, after two years. In the fourth case the patient did well. At this time the leg on the operated side is considerably smaller than the other. There is three and a half inches shortening, and almost complete ankylosis, the leg being held in a position slightly adducted and flexed.

In regard to the merits of the operation itself, the weight of surgical opinion, in view of the very satisfactory results obtained by careful and continued conservative treatment, is that the operation should be limited to those cases in which it is either impossible to carry out such treatment, or where conservative treatment carefully carried out is unavailing ; in other words, to consider excision of the hip as a life-saving operation. If, then, the operation is, as a rule, to be reserved to those cases where conservative treatment has failed—cases of extensive destruction of bone and soft parts,—in such cases any hope of preserving useful motion in such joints should be discarded, and the operation conducted in the hope of relieving the patient, exhausted by pain and long-continued suppuration, as speedily as possible.—*Boston Med. and Surg. Jour.*, Feb. 24, 1887.

Bradford (E. H.) on Subperiosteal Amputation at the Hip-Joint After Hip Disease.—A list of twenty-two cases of amputations at the hip-joint for hip disease, not included in Ashurst's tables, shows only three deaths. One case—the author's—is reported in detail.

The following conclusions would appear to be justified : Amputation at the hip-joint, in hip disease, should be regarded as the very last resort, contra-indicated by exten-

sive amyloid degeneration of the viscera, or a moribund condition of the patient.

The chances of mortality are not greater than the chances given in amputation of the thigh in general.

The chances of permanent cure (barring the mutilation) would appear to be greater than after excision at the hip-joint.

The amputation should be done subperiosteally whenever it is possible. An elastic tourniquet gives the best means of preventing hemorrhage.

Preliminary excision of the head of the femur, in freeing the upper part of the shaft, will be found to facilitate the amputation.—*Boston Med. and Surg. Jour.*, Feb. 24, 1887.

Bird (F. D.) on Sacro-Iliac Disease.

—The disease, I believe, is a rare one. The several causes are :

The strain of parturition.

Traumatism (a blow).

Over-fatigue, as in hip disease.

Struma.

Pelvic cellulitis.

Sarcoma, invading the joint from ilium or sacrum.

The symptoms of this disease vary very much in accordance with the exact situation of the inflammation, with the acuteness of the process, and with the constitutional predisposition of the patient. As a rule, the pain is dull and heavy in character, and diffused all over that side of the pelvis and buttock, also extending down the course of the sciatic nerve. It may, however, be localized over the region of the joint, or at the hip-joint, or the inner side of the knee. Approximation of the idea is a deceptive proceeding for diagnosis, as is also pulling them asunder. Pressure on the trochanter does not necessarily cause pain. In the form of the disease in which the lateral surfaces of the bones are affected there exists, as an incipient symptom, a peculiar feeling of weakness, of insecurity, of giving way at the lower part of the back, which is very characteristic, and which progresses with the disease into a pain, which suggests the idea of falling to pieces, or being rent asunder, when the upright position is assumed, or locomotion attempted. Increase of the superincumbent weight to be supported by the joint, stooping, and rising from a stooping position, always cause an exacerbation or an accession of pain. Abduction of the thigh when the patient is lying flat on a couch causes

pain referred to the whole side of the pelvis and hip. Deep pressure from the front of the abdomen in the direction of the synchondroses, and by the rectum, may produce pain and tenderness. In standing there is some lordosis; the weight rests on the sound limb, and the body is carried in that direction. The pelvis is oblique, and there will be apparent lengthening of the limb on the diseased side. In walking, the whole pelvis with the body above is swayed forward when the weight is on the sound leg, the ball of the foot being the centre of rotation. It is not so much a limp as an ungainly lurch of the whole side of the body.

Abscess may occur early, or may be deferred for months, or even years.

The treatment before abscess forms consists of rest in recumbency in the posture which is easiest for the patient, leeches, blisters, and the thermo-cautery. After abscess forms, evacuation and scraping out all diseased tissues.—*Australian Med. Jour.*, June 15, 1887.

DISEASES OF THE EAR AND EYE.

ABSTRACTS AND SELECTIONS BY A. T. MUZZY, M.D.

Stone (M.) on Ivory Exostosis Removed from External Auditory Meatus.—The patient has occasionally noticed a slight but offensive discharge from the left ear, since nine years of age. Since sixteen—he is now thirty-four—colds have rendered him deaf, each succeeding attack leaving him a little harder of hearing than the one before. One year ago he was attacked by severe pain in this ear and learned the nature of his trouble.

The hearing on the left side is very defective; watch barely heard on contact. The meatus almost completely blocked by a pinkish polypus-appearing body. Its attachment was to the upper, posterior, and inferior walls of the canal. The operation undertaken was by means of a chisel, the patient being put under the influence of ether. The chisel chosen was a small hollow ground, one such as used by Schwartz of Halle for opening the mastoid. The chisel was directed first against the upper portion, so that the groove corresponded to the shape of the canal, and by resting the

hand against the head, fear of slipping was removed. The chisel was tapped gently by the hammer, then moved and struck again until the inferior border of the pedicle was reached. This proceeding was repeated, each time using more force, until confident of having severed all its attachments. A pair of strong forceps with rotatory movement lifted the tumor out entire. The rest of the meatus was found to be free. Bleeding was very trivial. Hearing has improved steadily since. My reasons for using the chisel in preference to the American dental engine are these. First, I consider the operation with the chisel a safer one in a case such as this one. Second, that the growth may be got rid of at one sitting. The danger from slipping I do not believe so great as with the dental engine, and time much shorter. The measurements of the exostosis were 13 mm. long, 10 mm. wide, and 7 mm. thick.—*Liverpool Med. and Chir. Jour.*, July, 1887.

Burnett (C. H.) on the Successful Removal of an Exostosis from the External Auditory Meatus by Means of Bone Forceps and Chisel.—In April last the patient applied for relief. The exostosis was on the anterior wall of the right canal. It had been growing for fifteen years. It had a pedicle like a polypus, and was about a centimetre in diameter, covered on its outer surface with thick insensible skin. It nearly hermetically closed the external meatus. In removing this growth five minims of a 5% solution of cocaine were injected by hypodermic syringe into the concha near the exostosis. The tumor and the adjacent parts were mopped with a 5% solution of carbolic acid. The tumor was seized by specially devised bone forceps and a piece cut off. Little pain was caused. Nearly one half of the tumor was thus removed. At first the bone was like ivory, further it was somewhat cancellous. When so much had been accomplished it was found that the forceps could not act from the narrowness of the canal, so a small chisel and a hammer were substituted. And a few blows on the chisel directed at the pedicle removed it in bulk. The operation occupied one hour and twenty minutes. The pedicle was about one eighth the largest circumference of the tumor. After removal the remainder of the canal was found free from discharge and the hearing normal. The wound healed rapidly.—*Polyclinic*, New York, Aug., 1887.

Brunschwig on Hypopyon and Dental Caries.—It is a well-known fact that there is some connection between the eye and the teeth. Their nerve supply is through the same channel, the trigeminal. Two cases of hypopyon may show this more clearly. 1st. A lady, sixty-six years of age, consulted us for an inflammation of the left eye which had commenced six weeks before. This eye had been useless since infancy, yet had never given trouble. It was atrophied, its tension minus, the cornea was pearly, and there was an hypopyon, no photophobia, and almost no pain. We prescribed atropine, hot compresses, leeches to the temple, and calomel internally. The atropine and the hot compresses were continued two weeks without giving much relief. We examined her mouth, and found on the left side, in the superior maxilla, three roots painful on pressure. We advised their removal the same day; and the next day were surprised to note a complete disappearance of the hypopyon and a marked diminution in the pericorneal injection. The pearly appearance of the cornea also completely disappeared. Another case is that of a merchant suffering from acute iritis, with numerous posterior synechiæ. No history of rheumatism or syphilis. He was ordered to use every ten minutes for an hour a 1% solution of atropine and a 2% solution of cocaine,—after one hour to use two drops every hour; repeated applications of hot compresses, neapolitan belladonna ointment over the forehead and temple, six leeches in front of the right ear, and internally seven grains of quinine. The next day marked diminution of pain; only one of the synechiæ remain. This yields during the day. In two weeks the patient is discharged as cured. In two days he returns with fresh inflammation, and in addition a large hypopyon. He does not admit any imprudence on his part. Now on examining the teeth we find the second upper molar on the right side decayed. On removing it, the next day all the hypopyon has disappeared, and all inflammation likewise in the course of eight days.—*Recueil d'ophthal.*, Paris, July, 1887.

Fulton (J. F.). A Case of Almost Complete Self-Enucleation of Both Eyeballs.—A man from Winnipeg, thirty-eight years old, while on a protracted debauch, was thrown into jail. The attendant found in the morning that he was

blind. Examination showed both globes were torn from their connections and hanging loose in the conjunctival sac. The cornea had commenced to slough; the lids were retracted back of the eyeballs. The conjunctiva was swollen, thickened, infiltrated, so that it was difficult to distinguish the different tissues.

A few snips with the scissors of connecting conjunctiva was all that prevented the globes from removal. The muscles were all torn across, and the optic nerves ruptured seemingly close to the commissure. This self-enucleation had been accomplished by the patient forcing the thumbs into the external canthus back to the apex of the orbit.—*Am. Jour. Ophthal.*, July, 1887.

Sullivan, (M. B.). Complete Dislocation of the Eyeball.—The patient slipping on a lemon-seed fell towards a stove on which was one of the usual iron cover-lifters in an upright position. He struck on this object just over the eyeball, and as it passed into the orbital cavity the globe popped out. When seen both eyelids were completely inverted behind the globe. Applying a six-per-cent. solution of cocaine, I everted the lower lid and had it held by means of Charrière forceps by Dr. Ham, who assisted, and after much difficulty succeeded in everting the upper lid, when the eye slipped instantly into place. The vision is now perfect, and the conjunctivitis which followed has entirely subsided. The strain on the optic nerve was not over forty-five minutes.—*N. Y. Med. Jour.*, Aug. 27, 1887.

Jeaffreson (C. S.). Miner's Nystagmus.—This class of workers have a peculiar set of pathological conditions, due, without doubt, to their peculiar surroundings, and still more to their cramped position while working. Among these the neurosis named nystagmus is a very interesting one. This diseased condition varies widely in the severity and grouping of its symptoms. The lightest cases have the usual anæmic appearance of many of his class, and complains of inability to see clearly, or at all, in brilliant day or artificial light, and equally badly in dim light. No nystagmus is apparent, and can in such cases only be provoked by certain turns of the eye: this is usually by turning the gaze upwards, or, if this fail, by resisting the turning of the head in the same direction as the gaze. In more pronounced cases,

especially in the exaggerated ones, the nystagmus is easily induced by constant starts unprovoked. The patient at the same time grows dizzy, but without nausea. Lights dance by him; he stumbles against obstacles which he usually can avoid. The hemeralopia is very marked. The face now has an anxious, drawn expression, a modified *risus sardonicus*. When the nystagmus is excessive, the man may fall. They are able, by standing still, and by peculiar actions, to quiet this movement and its attendant dizziness. Sometimes even mental agitation, seeing some one suddenly enter the room where they are, will start the symptoms. And in all well-developed cases there is, during the paroxysms, considerable palpitation of the heart. This disease always occurs in that class of miners called heavers. Examination of the eyes shows hypermetropia in all cases, and progressing insufficiency or complete paralysis of the ocular muscles. As the day advances sight diminishes, but after sleep, with its refreshing, the muscular strain is relieved and the sight is much improved.—*London Lancet*, July 26, 1887.

DISEASES OF THE NOSE AND THROAT.

ABSTRACTS AND SELECTIONS BY CHARLES H. KNIGHT, M.D.

On the Nature and Treatment of Hypertrophies and Tumors of the Nasal and Pharyngeal Cavities.—In the *London Lancet*, Aug. 27, 1887, Dr. J. L. W. Thudichum gives the notes of thirteen cases illustrating various points of interest. He advocates the electro-caustic method of treatment as being accurate and satisfactory, and depreciates the practice of indiscriminate superficial cauterization in reflex nasal neuroses. These conditions he believes to be dependent upon a constitutional dyscrasia. Nasal disease may be the exciting cause, but the local lesion must be unmistakably developed, and is preferably treated by abscission. He seems to have a strong antipathy to the "snare," and cites a case in which a piece of wire had been left in the nose for eight months. (This is by no means a legitimate objection to the cold-wire snare, but rather shows inexcusable carelessness on the part of the operator. In the case of nasal polypi the manipulation of the cold-wire is incompa-

rably easier than the galvano-cautery snare, and, if necessary, cauterization may be practised later.)

Ozæna.—In the *Liverpool Med. Clin. Four.*, July, 1887, Mr. Richard Williams very justly protests against the indiscriminate use of this term. He would exclude such affections as syphilis, lupus, necrosis, and collections of pus in the antrum, and limit the application of the word to a lesion characterized by (1) fetor, (2) the presence of dry, hard, mucous crusts in the nares and naso-pharynx, (3) changed and atrophied mucous membrane and turbinated bones, and (4) anæmia. Each of these symptoms is considered in detail. The fetor is thought to be due, not to a micrococcus, as claimed by Löwenberg, which, if present, are probably secondary, but to the long exposure and retention of secretion, offensive and unstable at the outset. The secretion in ozæna, instead of flowing down the sides of the cavities, as in the normal condition, is seen to be coalescent, and to form a continuous layer over the mucous membrane, where it soon becomes dry and hard. On removing these crusts the mucous membrane is seen to be somewhat red and to bleed easily, and is evidently thinned, the nasal cavities being abnormally large. The epithelium may be lost, but there is no true ulceration. Although some observers hold that the atrophic is the primary condition, the weight of evidence is in favor of the theory that it is a later stage of a hypertrophic process. The two conditions have been found coexisting in the same patient in opposite nostrils. In all cases the sense of smell is lessened or abolished. Contrary to the opinion expressed by Löwenberg, that ozæna is never complicated with affections of the ear, Williams observes that many of his patients came to him for ear trouble. Lachrymal obstruction, a phenomena not generally noticed, has been seen by the author in many cases, and seems to show that ozæna is primarily an inflammatory lesion, and involves the nasal duct by direct extension. The treatment is tedious and must be long continued. Thorough cleansing of the parts by means of the douche or a probe armed with absorbent cotton is essential. The surfaces are then to be medicated with nitrate of silver, chloride of zinc, or equal parts of tincture of iodine, carbolic acid, and glycerine. Finally, insufflation of the cavities with a powder

of boracic acid, iodoform, or other non-irritating antiseptic, is to be practised. For constitutional treatment iron, arsenic, and cod-liver oil are relied upon, in conjunction with good hygiene. Although atrophied tissue cannot be restored, much may be done in this way to render the patient more comfortable and less annoying to others. In the discussion on the paper the question, "May not ozæna sometimes originate from infection?" was raised by Dr. Hunt. Still he regarded the bacillary theory unproven. In treatment he considered powders contra-indicated, since they tend to harden the secretions and retard their removal. A similar view was taken by Dr. Barr, whose opportunities for observation had been large. He advocated the use of an agent to stimulate the mucous membrane and increase secretion. He was in the habit of having the nostrils washed with a tepid solution of common salt, and occasionally with a weak solution of carbolic acid, salicylic acid, or permanganate of potash.

On Electrolysis in the Treatment of some Affections of the Skin and Mucous Membranes.—Among the cases cited by Mermod in *Rev. Méd. de la Suisse romande*, Feb., 1887, is one of intense coryza with great ulceration (?) of the septum and turbinated bodies, one of naso-pharyngeal catarrh with constant formation of pseudo-membrane. Complete cure resulted from the use of electrolysis, in five sittings in the former, and in two sittings in the latter case, other measures having entirely failed or given only partial relief. The effects are thought to be due to some special action, other than cauterization, upon the circulation and nutrition of the tissues. The positive rheophore should be large, the negative a metallic point, and they should be placed as near together as possible. For the nose the positive pole should be on the cheek of the side to be operated upon; for the pharynx it should be placed upon the nape of the neck. Pain may be controlled in a measure by cocaine. The occurrence of vertigo shows that the current is too strong. Six or eight cells of a zinc carbon battery are sufficient.—*Four. Laryngol. and Rhinol.*, Aug., 1887.

Galvanic-Cautery in Hay-Fever.—In the course of a discussion on "Reflex neurosis of the naso-pharynx," Mr. Geo. Stoxen stated that he had in two cases,

which he narrated, succeeded in locating the point of the irritation in the nasal fossæ, where the nasal branch of the ophthalmic division of the fifth nerve passes between the nasal bones and the cartilage to become superficial. He applied the galvano-cautery within the nostril in this region, with the result of effecting an ultimate cure, whereas the disease had previously resisted every form of treatment. In either case the patient had been the victim of violent paroxysms of sneezing occurring at regular intervals, of one week in the first and eight days in the second. No effect followed cauterization of the turbinated bodies, which were hypertrophied, a condition which disappeared spontaneously on the cessation of sneezing. Hence it was regarded as a result of the chronic congestion caused by the sneezing. The speaker said that he had since, with success, pursued a similar method of treatment in several cases of non-intermittent nasal neurosis.—*Brit. Med. Jour.*, Aug. 27, 1887.

Case of Unusual Injury to the Tongue.—The extraordinary reparative power of the tongue is well shown by a case reported by J. Hobbs in the *Medical Press*, July 17, 1887. A laboring man received a severe blow beneath the chin while his tongue was protruded from his mouth. The organ was nearly divided three inches from its tip, the main arteries remaining intact at its under surface. The wound was brought in apposition by means of five silk sutures, one of which cut through on the third day and had to be replaced. Ice was kept upon the tongue for eight or ten hours, and then a lotion of permanganate of potash was used. No inflammatory reaction occurred, on the sixth day all the sutures were removed, and on the thirteenth day the wound had completely healed, with perfect restoration of taste and sensation.

The Adenoid Tissue at the Base of the Tongue as a Factor of Throat Symptoms.—In a paper in the *Edinb. Med. Jour.*, Sept., 1887, G. McBride observes that the base of the tongue contains tissue analogous in structure to that of the faucial and pharyngeal tonsils. He refers to Swain, Curtis, Heymann, Betz, and others, who have contributed to the pathology of the subject, and gives brief notes of two cases, communicated to him by Michael, of Hamburg, in which the epiglottis became caught in the mucosa at the base of the

tongue. This condition has been observed more frequently in women than in men, and produces a feeling of a foreign body, pain usually localized but sometimes radiating, and fatigue in speaking. Rice and Stoerk have noticed the occurrence of cough and spasm. The author considers that contact between the tip of the epiglottis and the base of the tongue, without undue antero-posterior folding of the epiglottis on itself, may commonly be taken as an indication of hypertrophy of the lymphoid tissue. A sensation of pricking and of a foreign body, increased if the patient draws back his tongue as in gaping, are the usual subjective symptoms. The difficulty experienced by the patient in localizing these clinical phenomena has been especially noticed by Seifert in a recent article. McBride does not believe that a degree of hypertrophy sufficient to cause distressing symptoms is common, and he is not in accord with Swain, who has maintained that this condition is frequently the actual cause of globus hystericus. The hypertrophy may be destroyed by the galvano-cautery, or by nitrate of silver or chromic acid fused on with a probe, and applied under the guidance of a laryngeal mirror. The paper closes with the narration of a case. The epiglottis was caught in the hypertrophied oedematous tissue, but was easily released with a probe. Relief was temporary. Solid nitrate of silver fused on a probe was applied six or seven times at intervals of a few days. At first the sensations of pricking and of a foreign body were aggravated, but the symptoms disappeared with the gradual subsidence of the hypertrophy. Even then they could be reproduced by gaping or drawing back the tongue. When the symptoms are vague and the hypertrophy not prominent, the subjective phenomena may be for a time dispelled and a diagnosis reached by painting the upper surface of the epiglottis and the base of the tongue with a solution of cocaine.

Tuberculosis of the Tonsils.—After referring to the fact that primary tuberculosis of the tonsils has not yet been observed in man, and quoting from Virchow, Zeigler, and others to show the rarity of the lesion, Dr. W. Lubinski relates two cases of secondary tuberculosis of the tonsils. In one case a section of an excised portion of the tonsil showed large numbers of bacilli. The tubercular ulcers had no characteristic features. Occasional treat-

ment with cocaine and iodol insufflations gave no good results, the local lesions extended, and the patient soon died of exhaustion. In the second case the tonsillar ulcers healed after cauterization with the galvano-cautery, the disease meanwhile progressing in the larynx and lungs. In this case, unfortunately, the tissue of the tonsil was not examined, but scrapings from the ulcers contained numerous bacilli. For this reason the evidence as to the character of the ulcers may not be considered conclusive, since the pulmonary disease was far advanced, and the sputum contained large quantities of bacilli. The author accounts for the infrequency of recorded cases of primary tuberculosis of the tonsil on the ground of the impossibility of distinguishing the ulcers from those of syphilis, and by the fact that tubercular deposit seldom breaks down. Strassmann, in *Virchow's Archiv*, B. lxi., 2, cites a series of cases in which tubercles were found *post mortem* in tonsils apparently normal. Their degeneration, and the consequent formation of ulcers, may possibly be prevented by the great development of fibrous tissue in the tonsils. The prognosis in these cases is bad, on account of the pulmonary lesions and the danger of extension of the local disease. The lesion itself may be arrested by means of the galvano-cautery, and benefit may be derived from the use of cocaine and iodol.—*Brit. Med. Four.*, Aug. 27, 1887.

Secondary Hemorrhage Following Uvulotomy.—In the *Med. Record*, Aug. 13, 1887, Dr. G. B. Hope reports a case of hemorrhage occurring eight days after excision of the uvula. The bleeding was venous and was controlled by torsion. The author knows of no other recorded instance of secondary hemorrhage occurring later than the second day. (See article by Dr. E. C. Morgan on "Hemorrhage following Uvulotomy," in *N. Y. Med. Four.*, Oct. 16 and 23, 1886.)

A Simple Method of Procuring Deglutition where Such is Impeded by Reason of Extensive Ulceration of the Epiglottis.—In the *Lancet*, July 2, 1887, Dr. R. Norris Wolfenden gives a very simple plan, discovered by one of his patients, whereby swallowing may be accomplished with ease, and without producing that distressing cough so often seen in laryngeal phthisis after eating. It consists in lying flat upon the stomach with the

feet higher than the body, and in this position drawing fluid into the mouth from a glass through a tube. The patient who, in the sitting position, could swallow only with the greatest effort, and even then only by teaspoonfuls, in the prone position was able to drink the contents of a tumbler with perfect comfort.

Electric Cauterization and Evulsion of Morbid Growths on the Vocal Bands.—Dr. J. Solis Cohen recommends covering one side of the platinum blade of the electrode "with a thin layer of asbestos, upon which a plate of ivory is laid, the whole being firmly secured by the insulating material of the conducting wires." A point of practical importance is that the conducting copper wires of the electrode should be very thick; thus the greater resistance to the current is limited to the platinum terminal, and the shaft of the electrode does not become overheated. The shape of the conductor being less important than its bulk, the wires composing it may be flattened, so as to permit its easy passage through a contracted nasal meatus.

The olive-shaped blade of the laryngeal forceps does not easily grasp a small neoplasm seated upon the upper surface of a vocal band. To obviate this difficulty Dr. Cohen proposes a forceps having a square-ended blade, which, of course, gives a wider grasping surface. The blades are bent a little forward, in order more easily to reach the anterior extremities of the vocal bands. The instrument is useful in the removal of cysts, and in ripping of thickened tissues from the vocal bands. The blades, being applied separated to the surface of the bands, and closed while still in contact, must seize any prominence projecting between them. (Within the past week the reporter has used those forceps, as an adjuvant to the Mackenzie forceps, in the avulsion of a large papilloma of the larynx. Most of the neoplasm was removed by means of the latter instrument. The treatment has been nearly completed with the aid of Cohen's forceps in seizing remnants of the growth in the neighborhood of the anterior commissure.)—*Med. News*, Sept. 3, 1887.

Laryngeal Phthisis.—An interesting discussion upon this subject took place at the recent meeting of the *Brit. Med. Ass'n*. The debate was opened by Dr. Prosser James whose remarks were based upon five interrogations: (1) What is laryngeal

phthisis? (2) Is there such a disease as laryngeal phthisis? (3) What is the relation of bacilli to laryngeal phthisis? (4) Can cases of laryngeal phthisis recover? (5) What is the proper treatment of laryngeal phthisis? No attempt is made to give a precise definition or description of the disease, the fact being recognized that it may assume a variety of types. In answer to the second question, it may be said that, while the possibility of primary laryngeal disease has been denied by some, we sometimes discover laryngeal phthisis before the skilled auscultator can detect pulmonary mischief. With regard to the relation of bacilli to laryngeal tuberculosis, it seems to be necessary, in order to prove to some critics the presence of primary laryngeal disease, to find bacilli in the larynx, and demonstrate that the lungs are not affected. Dr. James has long been known as a firm believer in the curability of laryngeal phthisis, and he attaches importance to treatment. Local measures have great value, but the constitutional treatment is equally important. The use of sulphur fumes by inhalation is beneficial, and their effect may be measured by the proportion of bacilli in the sputum or scrapings from an ulcerated surface. Other disinfectants are more agreeable and therefore may be preferred. The speaker referred to the method, as practised by Ehring and Gougenheim, of scraping tubercular ulcers, and injecting lactic acid and iodoform under the mucous membrane, also to Kolischer's plan of injecting acid solution of phosphate of lime into localized tubercular tissue. The accidents which have in some cases attended interstitial laryngeal injections should induce caution in adopting these methods. Deep incisions, as advocated by Maurice Schmidt, and punctures and scarifying, as recommended by Marcet, are not favorably regarded. An open wound would tend to hasten the development of the lesion into the ulcerative stage, which is certainly not desirable. Dr. G. Hunter Mackenzie, in speaking of treatment, said that sedative or mildly astringent remedies are to be preferred to caustics. Of these morphine, iodoform, papayotin ($\frac{1}{2}$ to 5 per cent. solution), and cocaine, with its substitutes, caffeine and menthol, are the best. The local application or submucous injection of lactic acid seems to offer but little hope. Local applications by sprays, inhalations, or insufflations of antiseptics, such as iodo-

form, corrosive sublimate, and carbolic acid, have no specific effect upon the local lesions and do not affect the bacilli of tubercle, even when used in tolerably concentrated media and for prolonged periods. The operation of tracheotomy, or laryngo-tracheotomy, is warmly advocated. Two objects are held in view: (a) to insure to the larynx rest and freedom from irritation, (b) to give direct access to diseased areas for the purpose of scraping, excising, or otherwise removing or destroying tubercular tissues. Arsenic, as used by Ganghofner, is not a specific. The patient should be placed in an unirritating atmosphere, house residence at high altitudes is clearly contra-indicated. Mr. Lennox Browne expressed his preference for the galvanocautery for healing ulceration on the tongue and tonsil; for lactic acid, after scraping, in tuberculous disease of the fauces; and for menthol, over iodoform and iodol, in the larynx. Tracheotomy, except for urgent dyspnoea, is objectionable. The possibility of cure is doubtful. Dr. Woakes stated that in his experience of seven or eight years more relief of pain and more improvement in the local condition had followed vapors of a solution of sulphide of calcium than any other method of treatment. He advocates tracheotomy. Dr. Hooper, of Boston, had never seen a case of tuberculous ulceration of the larynx get well, although individual ulcers might heal. But little reference to Bergeon's treatment was made by any of the speakers, except by Mr. Browne, who seemed to be rather skeptical, the difficulty being in tuberculous cases to destroy morbid germs without injury to normal cells.—*Brit. Med. Jour.*, Aug. 27, 1887.

Local Treatment of the Diseases of the Trachea and Bronchi.—In *Monats. für Ohrenheilk.*, Nov. 4, 1887, Schaeffer states that he has confirmed the observations of Reichert regarding the instillation of fluids and the insufflation of powders into the trachea, which have been met with incredulity in some quarter on the ground that the application must produce spasm of the glottis. The patient should take a deep inspiration during the procedure. By passing the instrument through the glottis the bronchi may be injected. Michael, who reports the above paper for the *Four. Laryngol. and Rhinol.*, Aug., 1887, says that he has often injected Bell's solution during deep inspiration

After some hours the sputum could be found to contain white points of plumbic sulphide. He believes this to be the best method of treatment of laryngeal phthisis, subacute laryngitis, and tracheitis.

Kidd (Percy). Bilateral Paralysis of the Dilator Muscles of the Glottis with Subsequent Paresis of the Constrictors.—The first part of the paper is devoted to a review of the theories and experiments on this subject. Morell Mackenzie, Rosenbach, and Semon, whose views regarding the special vulnerability of the abductor fibres are well known, are quoted. Krause's opinions and experiments are given in full detail. References are also made to Fraenkel, Seifert, Simanowski, and others. His own patient had at first bilateral paralysis of the dilators, and afterwards paresis of the constrictors, a train of symptoms explained by the situation of the neoplasm producing them, both vagi being compressed above the origin of the recurrent nerves; the left recurrent being embedded along the lower part of the trachea. The author thinks the position of Semon and Rosenbach on the question of special vulnerability is sustained, and is not inclined to accept the mechanical explanation made by Gowers.—*Lond. Lancet*, July 16 and 23, 1887.

Newman (David). Diagnostic Significance and Therapeutic Indications of Laryngeal Symptoms Resulting from Pressure of Aneurisms upon the Vagus and Recurrent Laryngeal Nerves.—Four cases are related for the purpose of illustrating the following points: (1) That aneurism of the aorta and innominate artery may give rise to laryngeal symptoms only, but in most cases other signs may be discovered on careful examination. (2) That in the early stage pressure may cause urgent dyspnoea, laryngeal stridor, and paroxysmal cough. (3) That at a later stage paralysis occurs, usually unilateral, characterized by phonative waste of breath and imperfect cough, but without dyspnoea, except when reflex spasm is indicated on the opposite side, or when stenosis is caused by pressure of the aneurism. (4) That in certain cases tracheotomy should be performed, not only to save life, but as a remedial measure. Rosenthal and others are quoted to show that pressure upon one recurrent is not apt to produce serious dyspnoea, while compression of the vagus, by inducing spasm

of both adductors, may cause serious obstruction. It is important, with the idea of determining the question of tracheotomy to discover whether the obstruction is laryngeal or due to pressure lower in the air-tract. In the former case the head is thrown backwards, the larynx descends during inspiration, the stridor has a metallic ring, and the voice and cough are altered or suppressed. In the latter case the head may be thrown forwards, the larynx is stationary, the stridor is whizzing, and the voice is weak but not otherwise altered. Tracheotomy should be resorted to in order to secure rest, since death may occur from asphyxia or from rupture of the aneurism during a paroxysm of dyspnoea.—*Glasgow Med. Jour.*, Sept., 1887; also, *Brit. Med. Jour.*, July, 1887.

MEDICINE.

Porter (F. E.) on Typhoid Fever with Unusual Features.—In August of 1885 I was called to a store to see a man who said he had taken cold during the rain of a week previous; had headache, back and legs ached off and on ever since; nose bled the morning before, face anxious and pale, eyes seemed prominent and larger than usual. Patient thought he had indigestion, and had for a few weeks back resorted to an apothecary for plain soda, which seemed to him to help him. Some rolling and tumbling in bowels, though no diarrhoea, tympanites, or sensitiveness to deep pressure in iliac fossæ. Surface dry, pulse 116, temperature 104°, respiration 32.

Advised him to at once go home, take warm bath, apply warm pack to abdomen, and drink, in the course of a couple of hours, a tumbler of water containing

R Lin. ammon. acet.	3 i.
Syr. limonis	3 i. M.

and if sleepless and restless at bed hour take gr. vi. Dover's powder. The next morning he told me he slept well, sweat freely, and felt better. Pulse 94, temperature 103°. At 5 P.M., pulse 100, temperature 104.4°; advised spongings with soda water, and Dover's powders gr. iv. at bed hour, if necessary. On second morning his pulse was 100, temperature 102.8°, respiration 24, bowels had not moved, though often threatened to; tongue brownish coat on side; tip clean; said he "dreamed last night, and sweat in his sleep." 5.30 P.M.,

pulse 88, temperature 104.3°, nervous and restless, bowels uneasy.

No discernible change took place until the fifth morning. Pulse was then 92, temperature 102.6°; his friends said he was wandering during the night, and often required a strong man to keep him in bed. Up to this time he had been fed with plain, liquid, nutritious, and in part concentrated nourishment. At 2 P.M. was suddenly called, the patient having thrown himself in delirium about the bed, and could not be held. While there noticed his heart was fast failing, weakened action, frequent stops, irregular, surface growing cold, capillary circulation poor, nails blue, mouth wide open, and gasping respiration. Heaters, hot packs, hot coffee, hot water and brandy, and constant attention alone succeeded in whipping up the heart to renewed action and work.

7 P.M. Violent, and many men had to hold him; eyes bright and glistening, pupils dilated, saying nothing, but eying, hearing, and knowing all, refusing every thing. Pulse 140, temperature 102°, respiration 36; strength and power unnaturally increased, throwing men away from him in different directions. Consultation was sought with several physicians, and late in evening Dr. Thayer arrived. While rehearsing the condition in adjoining room, was suddenly called, to find patient wrestling with five men. Codeia, in grain doses, an hour apart was advised. At 2 A.M., after about five hours of extreme exertion, which of itself would inevitably wear out the patient in short time, and being unable to administer ether, which in many directions seemed preferable, I gave one half grain of morphia subcutaneously; then waiting forty-five minutes for results without finding any, three eighths more was injected. In fifteen to twenty minutes his exertions began to cease, and a controversial tack set in. At 4.30 A.M. he was asleep, which continued until 9.30 o'clock on the sixth morning. Pulse, temperature, respiration, state of surface, pupils, etc., corresponded to action of morphia in the system. During sleep patient sweat like rain, as indeed he had for past three nights. When he awoke his mind was perfectly clear, called for milk, toast water, clear water, beef-tea; bowels moved and bladder emptied voluntarily, and the patient commenced to advise about pulling together in pulling him through, though soon

after declared to those about him, he could not get well, "was all broke up," declared he must die, at the farthest, in a few hours. Large discolored spots were now discovered about his hands, arms, thighs, and knees, one or two about the trunk, with here and there an abrasion, notably over the joints. Petechiæ, usually found about the chest and abdomen, were not seen. Another failing of heart's action set in with its attendant symptoms, which were promptly met with hypodermics of brandy, etc.

At 2 P.M., he was fast becoming delirious, and seemed maniacal. Had he the strength of the preceding twenty-four hours, I have no doubt the same fight would have to be repeated. A hypodermic injection of one quarter grain of morphia sulphate stopped the muscular exertions, though the time was occupied with much talking and occasional sleep. At nearly midnight I left him, with pulse 145, temperature 100°, respiration 45, with directions to have brom. potass., sodium, et ammonium, and chloral hydrate aa. gr. x., in a suitable menstruum given per rectum, should raving again set in. Having a professional man nurse on hand at that time, I could rely on the execution of orders. He continued to fail during the night, and at 6 A.M., on the seventh morning of attendance, was called to find the pulse had been failing at the wrist for an hour, and now gone, heart's action 125, respiration sighing, and patient moribund. At seven o'clock death took place.

At 9:30 o'clock the undertaker found me and said my patient was fast growing unrecognizable, parts soft and dusky, abdomen swelling, ecchymotic spots, the size of a dollar to size of hand, appearing on back and legs. I saw him at 10 o'clock, and again at 2 P.M., when he was beyond recognition.

Extremities were fast amputating themselves,¹ and I told the friends that he died at the point of saturation with the poison; a gross statement, to be sure, but one I thought more readily acceptable to them

¹ In confirmation of the above, the undertaker tells me he was obliged to lift the body on a sheet in putting it into a hermetically sealed casket. At the funeral, while carrying the remains into and out of the church, the pall-bearers said that different ends of the coffin were heaviest, according as it tipped during conveyance, and sounds were heard as of fluid in motion while the casket was in their possession.

than any more refined elaboration of the condition.

Two or three reflections occur to me as I review this case. One is, the falling of the temperature when the cerebral irritation became pronounced.

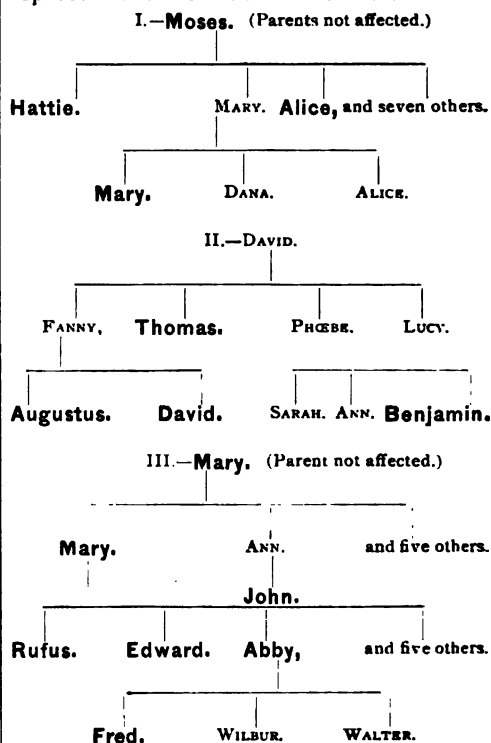
Another reflection is, the early appearance and desperateness of the nervous symptoms.

Lastly, the rapid decomposition after death. In this disease I do not remember ever to have seen such changes recorded. It must imply an unusual amount of the poison received. It is unusual, also, to see patients die thus early in the typhoid run. Emaciation is not pronounced, the fluids and fat are not yet reduced. Must it not mean that the *materies morbi* is the main factor in this instance; while the fever, an attendant upon the disease, has not as yet more than commenced to work its own destructive processes? I have thought that the excessive muscular exertions, also, were a factor in the rapid destruction. The amount of nerve-power necessary to execute such movements for so many hours without sleep; the amount of tissue waste of all sorts, with a poisoned nutrition, the blood, hastening to supply the loss of itself, would contribute *degeneration* for regeneration. One writer attributes the early appearance of delirium, not to any degree of fever that the patient as yet has had, but to the typhoid poison *per se*. And I see nothing in the way of supposing that a material, introduced into the system in amounts sufficient to so soon beget cerebral delusions, fancies, stimulating and perverting its energies to maniacal proportions, can, when driven throughout the economy at a heart gait of one hundred and forty and upwards, render every kind of structure, save the fibrous and bony, sufficiently pathological as, not only to cause early death, but, in warm weather, speedy decomposition beyond any recognition of the individual.—*Bost. Med. and Surg. Jour.*, Aug. 25, 1887.

Harrington (A. H.) on Hereditary Cases of Progressive Muscular Atrophy.—In February last there was admitted to the Danvers Lunatic Hospital a patient who, aside from mental trouble, was suffering from a very chronic form of progressive muscular atrophy. He stated that he had relatives afflicted with the same malady, and that there were traditions that it had appeared in several generations upon

his mother's side. Surmising that this might be one of those families, a few of which have been placed on record, where heredity appears to have exerted a powerful influence in propagating the disease for generations, an inquiry was begun with the purpose of verifying the patient's statements. This resulted in bringing to light fifteen well-authenticated cases, all springing from a common ancestry and extending over a period of about one hundred and fifty years. How many other cases there have been it is impossible to ascertain. Of some, traces have been obtained here and there, but of so indefinite a character that they have not been included in this account.

The following *schema* will readily show the manner in which transmission has occurred. It has been found convenient to arrange them in three groups. Moses, the head of group I, is a direct descendant of one of two brothers; David and Mary, the respective heads of groups II and III, are direct descendants of the other brother, the said Mary being the paternal aunt of the said David. The names in heavy type represent the individuals affected:



From the above we are able to deduct

the following facts: Of these fifteen cases nine are males and six females. They are the offspring of nine marriages. Transmission through the females to children has occurred in eleven cases, eight being males; through the male to children in four cases, three being females. Where the mother herself has been affected, the disease has been transmitted to children five times, where the father has been affected, twice. There are six cases whose parents were not affected.

It is said that the male sex shows a much greater tendency to the disease than the female. Out of one hundred and seventy-six cases collected by Friedreich only thirty-three were females. Another peculiarity is for the disease to be transmitted through the female rather than through the male, as shown in the cases described by Hemptemacher. While the cases being cited present exceptions, yet it may be seen that in the majority of instances they conform to these two principles.

Trousseau mentions a family in which the great-grandfather, grandfather, father, and son suffered from the disease. A still more striking example of atavism is presented in group III, where it will be observed that a mother, one child, four grandchildren, and one great-grandchild are all affected.

Eight of these fifteen cases are living. I have visited those within my reach, inquired into their history, and made a personal examination when permitted. The following is a brief account of a few of these cases:

Group I—Lydia, æt. forty-nine, dress-maker, when thirty-five years of age first began to notice the affection in her feet. At present there is marked atrophy of all the muscles of the feet, with flexion of the toes. The muscles of the lower legs are atrophied, but in a less degree. As yet there have been no symptoms connected with the upper extremities.

Alice, sister of the preceding, died, æt. fifty-three, of pulmonary disease. She began to be affected in the lower extremities at about the age of thirty-five. During the last five years of her life her upper extremities began to show the disease.

Group II—David, æt. sixty-five, muscles of the hands and feet much atrophied, fingers and toes contracted in flexion. Began to be troubled before he was twenty. Has followed the occupation of teamster nearly all his life.

Group III—Edward, æt. fifty-two, referred to as the patient now in the hospital. States that his trouble began at about fifteen years of age, and nearly simultaneously in the upper and lower extremities. For a few years the disease advanced pretty rapidly, but since the age of thirty-five there has been no marked progress, unless it is increasing contractions. At present there is atrophy of all the muscles of the hands and fingers, with a lower degree of wasting of the forearm. There is a similar condition of the feet and legs. For the greater part of his life he has been a stitcher on shoes; his last occupation was that of a peddler of small wares.

The history and present condition of his brother Rufus and sister Abby correspond so closely to his own that they would be essentially repetitions. They both began to be affected at about the age of eighteen. In Abby's case the affection appeared in her feet nearly two years before it showed itself in the hands. Rufus is a house-painter, and is still carrying on his occupation. Abby is able to do her housework.

Fred, æt. twenty-nine, sand-paperer, began to be affected in the feet when eighteen years old, and a year later symptoms appeared in his hands. To-day his upper and lower extremities are affected nearly as much as in the three preceding cases.

In this collection of cases, so far as I can learn, the disease has almost always appeared before the age of twenty, has advanced up to a certain point, after which its progress has been extremely slow. In no instance can I find that parts above the elbow or knee have been invaded to any extent, and no death has been attributed to this affection. The general health does not appear to suffer in any way, neither does longevity appear to be affected. One of these cases, it is said, lived to be a centenarian. Some of them have reared large families of children; they have all been able to indulge in some form of manual labor, by which a livelihood has been obtained, and I have yet to learn that one of them became a pensioner upon his friends until late in life, when causes connected with senility were more accountable than the life-long disease.

Edward is the only instance of insanity in the family within the recollection of his friends. The healthy members are robust-looking individuals, and the family history does not reveal any other neurosis. A

marked contrast is presented between the course of the disease in this family and that in the Wetherbee family in Western Massachusetts, reported by Dr. W. A. Hammond. In the latter the disease did not appear until the subjects were well advanced in adult life, when its progress was comparatively rapid, ending fatally in a few years.

These cases are very useful as showing the fact that progressive muscular atrophy of *hereditary* origin is not necessarily a fatal malady; that it may pursue an extremely chronic course; that, so far as general health and longevity are concerned, it may be innocuous; and finally, that, after advancing to a certain point, it may lose essentially its *progressive* character.

I feel that I should be betraying a confidence were I to publish the names of these people in full. I therefore represent the family name of their common ancestry as follows: P*****. Should cases springing from this same source be observed by others, I think that the name would be readily recognized. The people who have formed the subject of this paper are inhabitants of Eastern Massachusetts. The collateral branches are numerous, and are found in every part of the country.

I am indebted for family data in this paper to a carefully prepared genealogy, published a few years ago, in the absence of which I could not have traced these cases to a common parentage.—*Am. Jour. of Insanity*, July, 1887.

Glasgow (N. C.) on Measures for the Relief of Congestive Headaches.

—A few years ago I treated these cases with hot alkaline sprays, gently applied, and the use of hot fomentations, combined with the usual constitutional remedies. This mode of treatment has not been altogether satisfactory, and during the past four years I have substituted for it the local abstraction of blood, for which I can allege unqualified success. In many cases there is experienced an immediate relief of the pain, and in all there is a sense of the loosening of the constriction. A simple bleeding may relieve the headache, or it may have to be repeated in a day, a week, or a month. I have seen but few cases which were not permanently relieved by a bleeding repeated from two to six times.

To produce the bleeding, no cut is required. The cavernous body of the nose is simply pricked, and the blood flows

freely until the excessive tension has been reduced; then it ceases. The amount of blood drawn rarely exceeds one ounce; in many cases it is less than this, and in some cases a single drachm of blood removed will give the requisite relief. In cases of excessive congestion the flow will equal several ounces before it ceases, the quantity of blood being dependent on the distension of the vessels, and this corresponds with the severity of the symptoms. From a normal membrane, or where there is no excessive vascular distension, scarcely a drop of blood will flow from a simple puncture of the membrane such as would produce a free flow in this pathological condition. In cases where the mucous membrane is thickened, a sharper puncture will be necessary to bring blood. A lance-headed probe may be used in making the puncture, although a sharp-pointed bistoury, or any pointed instrument, will answer. The probe has the advantage that it does not excite the apprehension of the patients, many of whom become nervous at the sight of a knife, and dread the idea of being cut.—*N. Y. Med. Jour.*, Sept. 3, 1887.

Free (J. E.) on Lightning-Stroke Followed by Acute Bright's Disease.

—A farmer, of 35, was harnessing a horse, when it was struck and instantly killed by lightning, and every large bone in its body was comminuted. The man was struck senseless but recovered his consciousness in a very few minutes.

His right arm, which was closest to the horse which was killed, was numb. Paralysis of sensation was complete, while the power of motion was retained. This condition was only noticed from the elbow to the finger tips. The left leg, from the knee to the ends of toes, presented the same phenomena.

Three hours after the accident the writer arrived on the spot, and found the injured man standing at the front gate. His face was flushed, his eyes congested, and altogether he appeared to be laboring under strong mental excitement. When he attempted to walk to the house his left foot dragged. The effort necessary to get from the gate to the door caused a mild choreic spasm, which subsided as soon as he sat down. He said he was sleepy, but had been advised not to lie down. As soon as possible he was put to bed, and a weak sedative solution administered, more

to satisfy his mind than for any expected therapeutic effect.

The pulse was 100 ; temperature, 102° ; respiration, 23.

No pain was complained of.

On the following morning the patient was stiff and sore, and said he felt as if he had been beaten all over. The numbness in the arm and leg had somewhat abated, and he was able to get about the house without aid. A severe headache supervened during the day, and persisted for several days, when the characteristic symptoms of acute interstitial nephritis developed. At present, about one month from the time of the accident, he is rapidly improving.—*Med. and Surg. Reporter*, July 23, 1887.

Sweringen (H. V.) on Acute Mania Cured by Heroic Treatment.—The patient was a young Irishwoman who had six living children and had several abortions. About ten weeks after the birth of her last child she became maniacal. After four or five nights of sleeplessness and maniacal excitement, unaffected by ordinary hypnotics, the doctor gave her nearly a grain of morphine under the skin of the arm, and followed this by inhalations of chloroform. She slept until morning, when she awakened perfectly rational, took some nourishment and again went to sleep.

She thus slept and awakened for several days and nights, occasionally talking "a little off," as her husband expressed it ; but on the whole constantly improving, although she remained very weak.

It has been the author's experience in these cases that *small* doses only aggravate the condition, and a tolerance for very large doses is established by the very nature of the case.—*Med. and Surg. Reporter*, July 16, 1887.

Penn (J. W.) on the Prevention of Consumption.—The subject was a man, at the time my observations of his case were made, of about thirty-five years of age. His mother and two sisters had died of pulmonary tuberculosis. His case came under my care early in the fall of 1884, and was continued through the fall and winter of 1884-5. About ten years before, he contracted an acute attack of gonorrhœa, resulting in stricture of the urethra and followed by a chronic gleet, which had given him a great deal of trouble. The chronic inflammation had gradually extended by continuity until it invaded the

bladder and ureters. Urine generally turbid, and frequently from slight exposure or sudden atmospheric changes, it would be loaded with epithelial cells and a mucopurulent discharge. He had frequent threatenings of pulmonary disease ; would sometimes, for several weeks together, be annoyed by a persistent cough, attended, as he described it, with a constant tickling sensation in the larynx and trachea, fauces red, night-sweats, and a noticeable tendency to emaciation. During those attacks there was more or less expectoration of a tough, glairy mucus and muco-pus. While suffering in this way, there was always a marked improvement in the genito-urinary inflammation.

I was called to see him in September, 1884, and found him with an acute attack of nephritis involving the right kidney, which went on rapidly to suppuration, with the formation of a very large abscess. The abscess was neglected much too long ; in fact I could not prevail on him to allow me to either aspirate or incise the tumor, until finally the symptoms became alarming, and I assured him there was extreme danger from rupture into the peritoneal sac, and fatal inflammation. Consequently, in addition to an incision directly over the affected kidney, one and a half inches from the spinal column, there was a collection of pus just above the anterior superior spine of the ileum. There was an immense collection of exceedingly offensive pus, leaving a permanent double fistula, which I concluded, and said to my patient, would prove to be in his case an *escape pipe* or *safety-valve*, and possibly prolong his life by diverting the disease from his lungs. Subsequently, contrary to his wishes, I made no effort to heal the fistulous openings. He insisted that I should cure the fistula, declaring that he would rather die than live in that condition. Finally, I proposed to lay the matter before Dr. Austin Flint, New York, and get his advice in regard to it. So I wrote to Dr. Flint, describing his case and condition, and asked the doctor if, since the tubercle bacilli had been discovered in the sputa of phthisical patients, we might not find them in pus from any part of the body in individuals of the tubercular diathesis. Dr. Flint replied that he did not think the bacilli would be found in such pus, but very kindly offered to have a specimen of the pus from my patient examined. So I sent about a

drachm of pus, collected from the fistulous opening, and Dr. Flint replied that upon examination the bacilli were found in the pus, though in very small proportion, and, very strangely, as I thought, advised that the fistula be healed for fear it might infect the general system. I laid the facts all fairly before my patient, and frankly confessed to him that between the attainments, experience, and skill of Dr. Flint and myself there was no comparison; but at the same time, in regard to his particular case, I was compelled to say, with profound respect for Dr. Flint's great name and richly deserved reputation, that I took directly the opposite view of the matter, and was honestly of the opinion that as long as the fistula remained open he would enjoy immunity from an attack of pulmonary tuberculosis. He laughingly remarked that, inasmuch as Dr. Flint was a stranger to him and that he knew me well and was averse to any cutting or painful operation which might be necessary to heal the fistula, he would adopt my suggestion.

He slowly but regularly improved from that time forward. At the end of about six months from the date of the attack of nephritis, he was able to resume his business (that of druggist), and is now in the enjoyment of better health than he had for the last two or three years preceding the attack of nephritis. He is apparently free from any tendency to pulmonary disease. The urine has been normal ever since the formation of the abscess. He is free from gleet. He wears pads over the mouths of the fistulæ to protect his clothing, and has become so accustomed to his condition that it now scarcely amounts to any annoyance at all. There is a regular daily discharge from the fistulous openings, varying from a drachm to half an ounce in quantity, and occasionally there escapes from the posterior opening a brittle calcareous crust, not over a line in thickness, and about the size in length and width of the small finger-nail; its passage produces considerable irritation, lasting usually from three or four days to a week.

He frequently remarks that his *pets*, troublesome as they are, are his most valuable property.

From a close observation of the very satisfactory result in this case, I am of the opinion that if a seton were introduced at some point affording as little inconvenience as possible, and at the same time where

there is sufficient vascularity to insure a copious flow of pus (I would suggest a point below the axilla, on a level with, and about two inches posterior to, the nipple), this being done at the very first indication of the symptoms of incipient phthisis, attended with all of the hygienic auxiliaries that are recommended in such cases, would, as I believe, afford the most rational and effective preventive measures that have yet been discovered in connection with this the most dreaded and destructive enemy of human life.—*Southern Practitioner*, Aug., 1887.

Bell (J.) on a Case of Intussusception Extending over Twenty-Four Days; Natural Cure; Death from Cerebral Thrombosis.—The patient was a man of 64, who gave the history of intussusception, at ileo-cæcal valve, of at least four days' duration, with already local peritonitis and adhesions, and, from the extreme fœtor of his breath, probably already death of the prolapsed portion.

The question of laparotomy was discussed; but it was considered that if the diagnosis was correct, little good could be effected by the operation, which, in his exceedingly low state, it seemed would prove rapidly fatal. It was explained to his brother how serious the case was, and that the chance of recovery lay in the spontaneous escape of the prolapsed bowel and union of adhesions.

A good nurse was got. Every thing by the mouth was interdicted at once. A hypodermic injection of $\frac{1}{4}$ gr. of morphia was given, and rectal injections ordered. Ice was given to suck in small quantities. From that moment no further vomiting occurred; neither thirst nor hunger gave him much trouble. The morphia was repeated twice in twenty-four hours, and the injections of beef-tea and eggs were given at twelve hours', and eventually at eight hours' interval. After the seventh day of this treatment he was allowed a teaspoonful at a time of beef-tea and milk alternately, at first every hour, and then every half-hour, and all was retained. Flatus began to pass about the tenth or eleventh day from the onset, and on the fourteenth fæces began to come with a little grumous discharge. Both flatus and fæces were intensely offensive.

I was sent for again on the 21st July to see him on account of a hemiplegic attack, which had completely paralyzed his left

arm and leg, and had nearly deprived him of speech. He was then exceedingly weak and ill-looking, with an earthy complexion, but a better pulse than he had on my first visit. His temperature had never risen above 101° . No trace of the abdominal tumor could be felt, and all food was retained well; the bowels were acting fairly well without assistance, but no dead bowel had yet appeared. The paralysis was a most serious complication, probably thrombotic in origin.

On Wednesday 27th he seemed a little better and stronger, and passed a large piece of dead ileum, about nine inches in length. He died exhausted on 28th.—*Edinburgh Med. Jour.*, Sept., 1887.

Ferguson (E. D.) on the Recognition and Significance of Renal Albuminuria.—The author's conclusions from the facts presented in his paper, and from his clinical experience and observations, are as follows:

1. It is usually, but not always, possible to determine whether albumen is of renal or extra-renal origin.
2. If the urine be turbid, special care by acidulation and filtration may be necessary before deciding on the presence or absence of a small quantity of albumen.
3. Negative results in acid urine, particularly when the specific gravity is low, should only be accepted as final after repeated and varied tests have been tried.
4. Heat and nitric acid, Tanret's test, and the ferrocyanide of potassium test, when it may not be convenient to apply heat, used with the precautions before noted, will usually serve all practical purposes.
5. The microscope may be necessary in differentiating the source of the albumen.
6. Cases of renal albuminuria admit the possibility of a complete recovery in a certain proportion, except chronic diffuse nephritis, in which full recovery is doubtful.
7. It is possible that other sources of turbidity are occasionally accepted as albumen, notably mucin.
8. As simple as the process of testing for albumen usually seems, it is occasionally a chemical procedure of considerable difficulty, and the published results in cases admitting of doubt only become of value when all the facts have been stated.
9. Reports of cases of functional albuminuria, in order to be of value, require special care in describing the measures

used to avoid errors of observation.—*Gaillard's Med. Jour.*, Sept., 1887.

Jones (T. C.) on Leucocythæmia in a Child Eleven Months Old; Recovery.—In April, 1881, I was called to see a child who had been ailing for weeks. The body was well nourished, but the complexion of the whole surface very pale and blanched. On examining the abdomen a circumscribed tumor was discovered in the left side, extending from the ribs to the crest of the ilium, and to the right as far as the umbilicus. The cervical glands on both sides were also enlarged. The blood under the microscope showed an increase of the pale corpuscles. Iodide of potassium and dialyzed iron were given in small doses; cod-liver oil, milk diet, and frequent change of air were also prescribed. The tumor was painted with tincture of iodine night and morning. The above treatment was continued for months, under which the patient gradually improved and eventually recovered.—*Br. Med. Jour.*, July 9, 1887.

BOOK NOTICES.

Transactions of the Medical Association of the State of Missouri at its 13th annual session. E. E. Carreras, St. Louis, Mo.

The number contains, among others, articles on the following subjects: Neuro-Therapeutics; Bacteriology; Case of biliary calculi with absence of gall bladder; The proper food of infancy; Milk as a source or medium of infection; Dermatitis medicamentosa; Abdominal tumors; Early recognition of hip-joint disease; Hypertrophy and atrophy of the nasal mucous membrane; Gray atrophy of the optic nerve; and Abscess of the brain with post-mortem specimen, besides informal discussion on Injuries to the skull and Abdominal surgery.

Insanity: Its Classification, Diagnosis, and Treatment. A Manual for Students and Practitioners of Medicine, by E. C. Spitzka, M.D. E. B. Treat, 1887, N. Y.

The present is the second edition of this well-known work and is written in a scientific spirit that demands strict attention during its perusal. It is not a story book, the cases given illustrate principles and are well chosen.

The author's classification of the forms of insanity recognizes two groups. Group 1st, Pure insanities, containing 22 genera. Group 2d, Complicating insanities, containing 8 genera.

While this classification may do for the alienist, the general practitioner will, for some time, be content to decide a case to be mania, melancholia, dementia, or general paresis.

The chapters on the examination and medical treatment of patients contain much of practical value, and this book will doubtless be as acceptable to those dealing largely with the insane as to the general practitioner who rarely sees it.

G. B. P.

PUBLISHERS' NOTES.

Horsford's Acid Phosphate.—Acts as a tonic for the stomach and nervous system. Its specific use is to relieve irritation of the bladder, prostate, testes, and urethra, and to improve the nutrition of the nervous system. Its use is also indicated in all pains and inflammations. Wherever the nervous system is necessitated to spend its force and energy, the true remedy is acid phosphate. The greater the wear and tear the more necessary is it to supply nerve food. It is a remedy of the highest value in dyspepsia, sick headache, mental and physical exhaustion, nervousness, diminished vitality, neuralgia, and debility in nursing women. Physicians have used it with unqualified satisfaction. It is claimed that it is without an equal in the treatment of all nervous diseases.

Colden's Liquid Beef Tonic.—Colden's Liquid Beef Tonic is an excellent article for the purposes for which it is offered. I recall patients by whom it was taken with eagerness and *great benefit* after *domestic beef-teas* and other *beef preparations* had become repulsive.

Dr. W. A. M. CULBERT,
Newburgh, N. Y.

Acid Mannate.—I have used Acid Mannate on one case, and liked its action very much. J. R. HENDERSON, M.D.
Sun Hill, Ga.

Aletris Cordial.—Aletris Cordial is unquestionably an excellent remedy in the diseases peculiar to females. So far, my cases have yielded promptly to its influence.

A. J. HAILE, M.D.

Savannah, Ga.

Crystalline Phosphate.

BUFFALO, N. Y., October 11, 1886.

Provident Chemical Works, St. Louis, Mo.

DEAR SIR:—Mrs. Harvey has taken the "Phosphate" and has received a great deal of benefit from it, giving her increased strength. Will you send a bottle of it, the smallest you sell, giving the price, and I will remit by return mail.

Respectfully yours,

C. W. HARVEY, M.D.

McArthur's Hypophosphites.—It will pay you to try McArthur's Syrup Hypophosphites Compound (chemically pure) in cases of Phthisis, Nervous Diseases, or Wasting Diseases of the System, and you will be well pleased with results.

Report your experience with them to McArthur Hypophosphite Co., Boston, Mass., and mention the ANALECTIC.

Phillips' Emulsion of Cod-Liver Oil.—Our readers' attention is respectfully called to the advertisement of the above well-known Cod-Liver Oil, on top of title-page. Send for sample.

For Feeble-Minded Youth.—Send to the Superintendent of this well-known asylum for full particulars, Dr. Geo. Brown, Barre, Mass.

Abdominal and Uterine Supporter.—All our readers should have a catalogue of the supporters made by Flavell & Bro., of Philadelphia, Pa. See advertisement.

Lactated Food.—Lactated Food is the very thing. It is undoubtedly the best food in the market for children suffering from wasting atrophy. I have tried various preparations in those cases, and find Lactated Food "par excellence." If physicians will use more of it the infant mortality will be largely reduced. J. W. RITCHIE, M.D.
Stephenville, Texas.

Bromida, Papine, and Iodia.—The above preparations have been successfully manufactured by the well-known chemists, Messrs. Battle & Co., of St. Louis, Mo., for a number of years. This firm has just been awarded a verdict in their favor, restraining different competitors from ever introducing or selling any other preparation under the name of the above. The reputation gained by Messrs. Battle & Co. for their imprint is an enviable one. See their advertisement, and send for their interesting pamphlet, mentioning the ANALECTIC.

Stammering.—Dr. E. S. Johnston, of Philadelphia, Pa., will be pleased to communicate with any of the profession having patients suffering from stammering, stuttering, and all defects of speech. See advertisement, and send for circular.

Uterine Supporter.—See advertisement of Messrs. Halsey Bros. in this issue; it is well worth while reading their catalogue, which can be obtained by mentioning this journal.

Folding and Reclining Chairs.—An "Invalid Chair" is an indispensable article for physicians' and surgeons' use; those manufactured by the New Haven Folding Chair Co. are of the very best. See their advertisement on another page, and send for price-list.

THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

VOL. IV., No. 11.

November, 1887.

WHOLE No. 47.

LEADING ARTICLES.

On the Infectious and Contagious Nature of Tuberculosis.—Cadéac and Malet¹ have performed experiments to determine the transmissibility of tuberculosis by expired air of phthisical patients, or by the atmosphere in which they live.

They have decided to their own satisfaction that animals, healthy or diseased, made to breathe the air expired by very sick tubercular patients do not contract the disease; also that animals living continuously in an atmosphere breathed by other tubercular animals do not become tuberculous; also that animals inoculated with the water condensed from the breath of tubercular patients, do not become tuberculous. On the other hand animals that cohabit completely, *i. e.*, eat, drink, live and sleep, with tuberculous animals do contract the disease in a large proportion of instances. This transmission the authors attribute to a contamination of the common food and drink of the animals.

They find that the air of apartments containing phthisical patients does contain the tubercular bacilli, but consider that they come, not from expired air, but from the drying up of poisoned secretions, sputum, saliva, and urine, reduced to an impalpable dust and held suspended in the atmosphere. The authors conclude that there is no danger in congregating healthy and much more weakly or diseased persons with tubercular patients, but that the danger lies more in a contamination of food, drink, and linen than in the breathing of infected air.

Leudet,² from a careful study of hospital statistics, concludes that the propagation of pulmonary tuberculosis by hospital contagion is not demonstrated.

Every one has been struck by the fondness flies seem to evince for the spit-cups in a hospital ward. Spillmann and Hausshalter³ collected numerous flies, which had been some time engaged in feeding on the expectoration of tubercular patients, and placed them living under a bell-glass.

The next morning many had already perished. The intestines of many of the dead flies contained an immense quantity of tubercle bacilli and their excrement (the fly-specks on the inside of the bell-glass) also was full of bacilli.

Flies thus contaminated, die, dry up, and are converted into dust, and thus disseminate their contained bacilli; and as they die upon the ceiling, hangings and carpet they widely distribute their germs of tuberculosis. They may also pollute food by their excrements.

It is not likely that the sojourn of the bacilli in the dried body of a fly or in its excrements can alter or abolish their vitality, as it has been experimentally shown that they withstand dessication, putrefaction and even the absence of oxygen.

To avoid this possible method of spreading tubercular poison the authors recommend the use of glass or porcelain spit-cups with covers, and the sterilization of the expectoration by boiling water or a five per cent. solution of carbolic acid.

Bearing perhaps upon the transmission of tubercular poison by means of dust in the air, are the recent claims that acute tuberculosis is more often seen after an excessively hot summer and is developed more often among continual residents of a hot climate than among those who live in a cooler place or seek a cooler climate during the hot months.

Dr. Th. H. Buckler says⁴: "That heat plays the leading part in the etiology of

¹ *L'Union Médicale*, Aug. 27, 1887.

² Noted by *Lond. Med. Record*, April 15, 1886.

³ *L'Union Médicale*, Aug. 27, 1887.

⁴ *Bost. Med. and Surg. Jour.*, Aug. 4, 1887.

tubercular phthisis, there is ample proof in the fact that true acute consumption, a disease lasting from fifteen to thirty days at most, from its commencement to the always fatal termination, occurs during or immediately following a heated term.

"In the last fifty years I have seen thirteen cases of acute tuberculosis, the average duration of which was eighteen days. In a majority of them the first sign noticed was anhelation from exercise or slight exertion of any sort. To the ear and hands the signs were negative, nothing being heard but an occasional sibilant or sonorous râle. In these cases hundreds of tubercles are deposited in every lobule of both lungs, no single part of the pulmonary parenchyma escaping. But, as a rule, when the nervous system is depressed by heat, tubercles are deposited, most generally at the summit of one or both lungs. There they remain dormant until cold weather sets in, when the patient begins to cough, or in one out of five cases he may raise a little blood, which symptoms are noted as the beginning of the attack, when in fact the seed giving rise to these symptoms had lain dormant there ever since the heated term of the previous summer."

Dr. G. H. Boyland adds the weight of his testimony to that of Dr. Buckler, when he says: "My experience has been that the tuberculosis deposit which undoubtedly takes place during the heated term, may remain in the system much longer than the setting in of cold weather, and not develop till the following spring. I refer only to cases of acute miliary tuberculosis. In one of those occurring in my own practice, the disease did not make its appearance until the latter part of March of the next year after an excessively hot summer."

According to the reports of the Charité Hospital, at Berlin, the mortality from acute miliary tuberculosis is much greater during those winters preceded by excessively hot summers. In many of these cases the anamnesis is unable to reveal the slightest hereditary taint, demonstrating conclusively that excessive heat was the direct exciting cause, as Dr. Buckler suggests.

It is stated that the mortality from consumption in St. Augustine among those

living there all the year round, is much greater than in towns of the same number of inhabitants farther north—a fact easily accounted for by the excessive summer heat prevailing in Florida.

The proverbial antipathy of the Italians to going in the sun may account for the small number of cases of acute miliary tuberculosis occurring among them.

Blaine has probably studied bovine tuberculosis and its relation to public health more scientifically than any other American writer, and he says:

"During the past two and one-half years I have examined over four thousand head of animals in different sections of this State, and I find that the disease is more prevalent than is generally known. The majority of animals that I have examined were milch-cows, and I found twenty-one per cent. manifesting symptoms of the disease; but perhaps not over four per cent. of them manifested pulmonary lesions. I have visited some herds where at least fifty per cent. could be shown to be tuberculous. The disease seems to be much more prevalent in some localities than in others. For instance, in low, wet, and marshy districts it is very common; also in places where animals are poorly fed and kept in close confinement, and in poorly ventilated stables.

"I visited New York City stock-yards during the month of July last; also examined a number of herds about that city and Brooklyn. The morning I visited the stock-yards at 159th street, in company with Mr. Romane, a meat inspector, I saw thirteen cows that were offered for sale, three of which were badly diseased, and one of the three was a cow thirteen years old, and manifested pulmonary lesion. I acquainted Mr. Romane of the fact, and when he consulted the manager of the yard in regard to the cattle, he said that they had been sold to parties in Jersey City for milkers. I visited herds that furnished milk for the city of Brooklyn, and I did not fail to find tuberculous animals in every herd that I visited, and in some herds to a great degree. But I was astonished in not finding more disease than I did, as the manner in which the animals were being cared for was not only unhygienic, but cruel, especially in winter, as several herds-

¹ *Boston Med. and Surg. Jour.*, Aug. 25, 1887.

² *N. Y. Med. Rec.*, Jan. 15, 1887; also *MEDICAL ANALECTIC*, March, 1887, p. 134.

men informed me that their animals were tied in those small barns in the fall, and were not taken out in the open air until spring time."

During the fall of 1883 tuberculosis broke out among the herd of cattle at the Willard Asylum, necessitating the killing of *ninety* or more adult and young cattle. The course of this epidemic was such that no extra proof was needed to stamp the disease as acquired in most instances, and not inherited. The remarkable transmission of the disease from the cattle to the swine of the institution, is described by the author, as follows :

"In proof that the disease may be acquired by the ingestion of tuberculous substances, allow me to call your attention to the asylum herd of swine, which numbered nearly three hundred head. These animals were kept in different yards. In one, the breeding sows ; in another, the half-grown pigs, and in the third yard, which was adjoining the slaughter-house, were kept the large hogs which were being fattened. The hogs in this latter pen had access to the offal from the slaughter-house, where a number of tuberculous cows had been killed. Later in the fall a number of the large fat hogs died suddenly in full strength, and on post-mortem were found highly tuberculous. The disease, however, did not present the same pathological conditions as in the cows. The disease seemed more especially confined to the abdominal viscera and the glandular system, the lungs being rarely affected. In those cases that died suddenly I found a tubercular peritonitis, to which was attributed the cause of death. During the killing season many were found diseased, there being large metastatic abscesses in different portions of the body, but more especially in the side ; and in the sows the rudiments of the milk-bag were often the seat of abscess. Also the joints were frequently affected, many of the hogs, both large and small, became lame. During the winter a number of them became partially paralyzed in their hind parts. The paralysis progressed, and finally they were unable to use their hind limbs at all, and for several days three of them moved about, walking upon their fore limbs and dragging their hind parts. Still they were fat, and seemed to eat equally as well as the others. Finally they were killed, and on post-mortem

the bodies of the vertebræ in different portions of the column were found to have undergone caseous transformation. The cord at these points was softened, and in some cases completely obliterated.

"There were three sows in this yard that proved to be with pig. They were taken out and put with others in another yard. One of these sows, shortly after pigging, became paralyzed similarly to those that I have already alluded to. In about three months her young pigs became hollow-backed ; they walked about with their bellies touching the ground. Finally they were killed. All were found diseased, and the bodies of the vertebræ very incompletely formed. The other two sows became paralyzed and were killed before pigging, but unfortunately an autopsy was not held.

"After the killing of all the swine that had access to the offal, and disinfecting the yards, we have since had no more disease in the herd."

The author introduced into the respiratory tract of animals tubercular material from both cattle and man, with about identical results. The tubercular disease, which ensued in about fifty per cent. of the cases, seemed about the same in each instance.

He agrees with Cadéac and Malet, that the expired air does not contain germs of the disease in sufficient quantities to infect.

Galtier¹ has proven experimentally that tubercular muscle and milk preserve their virulent properties even when submitted to a temperature of from 140° F., which is about the temperature to which rare meat is subjected.

Neither dessication at a certain temperature, nor salting (pickling or corning), if not prolonged, nor a long sojourn in water, nor putrefaction, nor freezing, destroys the virulence of the tubercular poison.

He also points out² that the blood and flesh may not be contaminated, while the milk of tubercular cows is poisonous. He has produced genuine tuberculosis in the lower animals by the inoculation of whey and cheese, even salted, and two and a half months old. His experiments show that not alone the raw milk but the manufactured products from it are dangerous, when derived from a tuberculous animal.

Galtier calls attention³ to the fact that

¹ *Jour. Méd. et de Chir. Prat.*, Aug., 1887.

² *L'Union Méd.*, May 28, 1887.

³ *Jour. d'Hygiène*, July 21, 1887.

fresh blood or powdered dry blood is used in the clarification of wines, and that tubercular infection may be brought about by this means, as it has been experimentally proven that the bacilli resist the effect of alcohol for a short time, and that of diluted alcohol for a considerable time.

Dr. Helen L. Betts relates¹ the following case of tubercular infection in a child :

A child, eighteen months old, of healthy parentage, contracted a gastro-enteritis from eating bananas and getting chilled. Convalescence was retarded for a few days by a trifling lobular pneumonia and bronchitis; complete recovery took place; two months later indubitable symptoms of tubercular meningitis set in, the disease proving fatal in two days; no autopsy was obtained.

On inquiry, it was found that the baby had been tended for three months by a nurse-girl, with the following history :

"Upon inquiry, I learned from the nurse-girl's mother that she had already lost six older children, all dying at from six to eight years of age with consumption, and this girl was apparently fast following them. They inherited the tendency from their father, who died very suddenly at thirty years, of some unknown cause. He, however, had had a very severe cough for some time, and his mother died of consumption. The nurse-girl had come to take care of the patient just as he was recovering from an attack of bronchopneumonia, described above. She was exceedingly fond of her charge, constantly hugging him up in her arms, and kissing him upon the mouth, and holding his face against hers. The girl had a severe cough and a terribly offensive breath, but she was neat and tidy in appearance and kind in her manner; and it is probable that her demonstrative devotion was one of the fatal factors in the case."

Dr. Zina Pitcher accounts,² in part, for the great prevalence of tuberculosis in Alaska by the following disgusting custom of the natives :

"I chanced to be in a house, visiting a patient, during the preparation of the evening meal. The klutchman (wife) was assiduously chewing a mass of something, spitting it, when thoroughly moistened,

into a spider. Watching more closely, the substance chewed proved to be sea-weed, prepared in the fall by pressing into square cakes and drying. This she picked to pieces and thrust into her mouth, masticating it as described. The spider, at last becoming full, a quantity of seal, or herring oil, was poured over it, a few hot coals stirred in, and later, warmed slightly over a fire. Of this delicate dish the entire family partook briskly. This klutchman was a consumptive, and the patient (her son) was also suffering from the same complaint.

"A berry is prepared similarly, with the exception that the siwash (man) does the masticating. After observing these families pursuing this disgusting custom, and noting the percentage of cases, the families having partially and wholly adopted 'Boston manners' were investigated, and the percentage found materially less."

Leon Petit reports³ the following remarkable case of tuberculous transmission :

The victim was a dog, about eighteen months of age, which was very devoted to his master, æt. 40, who had both pulmonary and laryngeal tuberculosis. Several times, after a violent fit of coughing, the patient mechanically vomited the contents of his stomach, and the dog instantly ate both sputum and food. In a short time the dog developed all symptoms of pulmonary phthisis, and died three days after his master. An autopsy showed that the dog had a subacute tubercular pleurisy, complicating a localized pulmonary tuberculosis.

M. Coret, a veterinary of Aubervilliers, reports a similar case : A dog, purchased at the age of two months, remained pretty well up to the age of three years. At that age it developed symptoms of phthisis, and died, an autopsy showing it to have pleurisy and pulmonary tuberculosis. Eighteen months before, the mistress of the dog, æt. 32, died of chronic phthisis. In later stages of her disease, the dog had never left her, and when the patient was bedridden, the animal slept at her feet.

Dr. F. I. Knight reports⁴ the following case of tubercular contagion :

"In July, 1885, a young lady of 19, came to my office with a history of cough of nine

¹ *Am. Jour. Obstet.*, etc., June, 1887.

² The Contagiousness of Phthisis, *Med. Age*, April 25, 1887.

³ *Jour. de la Soc. de Méd. et de Phar. de l'Isère*, July, 1887.

⁴ *Jour. Am. Med. Ass'n*, Oct. 15, 1887.

months duration. I found signs of phthisis in one lung. Her father was a very strong man; her mother had died of some nervous trouble after child-birth. There had been ten children, five of whom died in infancy, none of them with any brain or lung disease. There had been also six half-brothers and sisters, one of whom had died in infancy. Of the uncles and aunts on both sides, only one uncle had died of phthisis. The patient gradually declined, and died April 15, 1887. She was accompanied in her visits to my office by an older sister, 23 years of age, who had given up every thing to attend to her. The sister, while not robust looking, appeared well, and said that she had always been so. She occupied the same room and bed with her sister. This I protested against, and advised her to go out regularly every day for walks in the fresh air. The last record made of their visits to me was in the latter part of October, when the phthisical patient became too sick to come to me, and went under the care of her family physician in a neighboring city; she died, as I said, on the 15th of April. On the 19th of April the sister came into my office with the following history. She had continued to attend closely upon the invalid all winter, and had disregarded all my advice. She had even slept with her sister up to within five weeks of her death. She was with her night and day. During the latter part of her sister's life her breath was so offensive that she could eat almost nothing, and only kept herself up by the free use of stimulants. She stated that she had had a little dry, hacking cough for a month. She breathed rapidly, but said there was no dyspnoea. On examination her pulse was found to be 140. Temperature 104°. On examination of the chest, subcrepitant râles were heard in both upper lobes, front and back, and the diagnosis of acute pulmonary tuberculosis was made. Examinations, April 26 and May 3 confirmed the diagnosis. On the 21st of May, she came to my office so weak that she had to be assisted from the carriage to the house. She reported hæmoptysis of several months two weeks before. She was so weak that I did not examine her chest. Pulse, 160; temperature, 103.4°. I did not see her again, and she died June 17, 1886, about two months after I first examined her, and three months after the beginning of the dry cough."

In 1875, Flindt, of Denmark, as quoted

by Ouchterlony,¹ published the following interesting observation :

"In the autumn of 1872, an artisan, his wife and five children (four sons between the ages of three and a half and fourteen years, and a daughter fifteen years old), went to live in a village in Denmark, where they occupied a small room with another family, consisting of a man, his wife, and a grown-up son, both affected with febrile phthisis. They remained in this crowded and confined abode, in which the air was rendered poisonous by the presence of the patients, until January 3, 1873, when they left the place for a more healthy dwelling. Before this, however, at the time of Christmas, the five children, who had been previously in good health, became affected by scrofula, suffered from pulmonary disease; and the evolution of the disease was so rapid that they all died after the respective periods of seven weeks, three months and a half, and seven months. The daughter, whose age was fifteen years, and who had only remained one day in the infected room, was attacked like her brothers, and it was her death that occurred at the end of three months and a half. An autopsy was made in one case, that of the youngest boy, who lived for seven months. Several caverns were found in the right lung, numerous foci of yellow infiltration in the spleen, and tubercular ulceration in the small intestine, while the mesenteric glands were swollen and in a state of caseous degeneration."

In 1878 Reich¹ published a contribution which is perhaps even more complete and convincing :

At Neuenberg, a village with thirteen hundred inhabitants, two midwives practised their profession, dividing in almost equal proportion the obstetric practice of the place. In the winter of 1874 one of them was attacked with phthisis, and died in 1876 from the effects of the disease. Of the infants whose birth she had attended between April 4, and May 10, 1876, ten died of tubercular meningitis, July 11, 1875, and September 29, 1876. Not one of these ten children was under the influence of hereditary predisposition. In the practice of the other midwife, during the same period, not a single child was affected with any form of tubercular disease. The first midwife was in the habit of removing by aspiration the mucous products which obstruct

¹ *Am. Pract. and News*, July 9, 1887.

the *prima via* in newly-born infants, and when the slightest degree of asphyxia occurred direct insufflation was practised. It should be added that tubercular meningitis is not endemic at Neuenberg, where, in fact, it but rarely occurs, and that, during the period between 1866 and 1874, of ninety-two children who died in the first year of their life, Reich observed but two cases of this disease, while in 1878, of ten children who died at this age, he observed but one case and that in an infant whose parents suffered from tuberculosis.

Dr. L. Brühn, in 1880, reported a number of cases illustrating the communicability of tuberculosis :

A tuberculous man married a woman of healthy family. The husband died. The wife became tuberculous ; so did her sister, who had lived with them during the husband's illness. This sister was subsequently married to a robust man of very healthy family. He became afflicted with tuberculosis ; and his niece, who had also lived a considerable time in the house with them. One of their children died of tubercular meningitis ; two have marked signs of pulmonary tuberculosis, one only being in good health at the time of writing.

The servant girl who had nursed the first mentioned man's wife in her last illness became tuberculous, went back to her own home and died. Her sister became infected by her. Both their parents attained a very high age, and there had never been any consumption in the family.

It is hardly possible to furnish more striking and direct clinical evidence on any subject than this.

Dr. Wm. Bruce, of Oberlin, Ohio, furnishes some very convincing observations in the *Medical Age* for June 10, 1887. They were made by him about eight years ago :

"A strong, healthy family, consisting of father, mother, five boys, and five girls, all entirely free from any tendency, hereditary or acquired, to any disease whatever.

"One of the girls, unmarried, aged twenty-four, went to an adjoining town to teach in a union school, in place of a lady teacher sick with a bad cough—which proved to be due to tuberculosis. In addition to her duties as a teacher, she assumed the care of this sick teacher. In order to allay the violent paroxysms of coughing to which this sick girl was subject, some sort of a powder had been used in the throat by means of an insufflator. As a substitute

for this device, the nurse placed the powder in a glass tube, from which she blew it directly into her throat with her own mouth, and thus inhaled directly the breath, often during a paroxysm of coughing.

"In the course of a few weeks she herself was taken with a severe cough, compelling her to give up her school. She came home and placed herself under my care. A careful examination of the lungs revealed a slight consolidation just below the left clavicle, with an inflamed condition of the throat, strongly suggestive of a deposition of miliary tubercle, and I attribute the condition to contagion.

"After a thorough course of local and constitutional treatment, in the course of six months health was apparently restored. Some three years afterward, however, following a severe cold, a cavity formed in the left lung, and after lingering along for nearly a year she died of consumption.

"While at home during her first sickness, and while under my care, a younger sister, aged twenty-two, and single, who had entire care of her, used on her throat, without my knowledge, the powder above referred to, by blowing it into the throat, in the same way as had been done in the case of the sick teacher, often during a violent fit of coughing. The result was an infection precisely similar to that of her sister, but, unlike her sister, her disease continued unchecked, and she died in a little less than a year, of consumption.

"A still younger sister, aged eighteen, took the entire care of the last patient, and became in the course of a few weeks infected in the same way, and died also of tuberculosis.

"During this daughter's sickness I accidentally saw the mother in the act of blowing with her mouth through a glass tube some of the powder into her sick daughter's throat, in order to allay a violent fit of coughing. I immediately stopped her, telling her the danger of such a course, and that I supposed they always used a powder blower which I had provided for that purpose, and was horrified to find they had failed to use it.

"I had previously ordered the free use of disinfectants, and that all excretions, with the sputa, should be buried.

"The mother had already become infected, for she sickened and died, with the same intensely congested throat and dreadful paroxysms of coughing, ending in destruc-

tion of lung tissue and death from consumption.

"After the mother's sickness the two elder sisters came home and had the care of the mother and the household, but were careful not to inhale the breath, and followed out my instructions in reference to the local applications to the throat. They both escaped infection, and are well to-day, as are also the father and two brothers, none of them having suffered from a cough (except from a slight cold), and have always enjoyed the best of health."

Gosselin¹ has endeavored to secure an attenuation of tubercular virus, by the inoculation of which he could produce an immunity against tubercle in other animals. All means attempted to accomplish this end have failed. The virus remains always the same, and always produces tuberculosis when inoculated, or, when it fails, does not fortify the system against a second inoculation.

The author has also sought some substance which will sterilize the organism against the production of bacilli. The salts of mercury are inefficient, but with iodoform it is different. There is nothing germicidal about iodoform, but a continued saturation of the system with it will stop the development of the virus for the time being; but the administration being stopped, the disease progresses to a fatal termination.

Raymond and Arthaud² have likewise failed to secure immunity from vaccination, but have found in tannin what they consider almost a prophylactic against tuberculosis. Rabbits, to whom tannin is freely given, seem refractory to tubercular inoculation.

Raymond states that tannin, when given in daily doses of from 15 to 60 grains, has a better effect in cases of acute tuberculosis than has either iodoform or the bisulphide of carbon.

Penzoldt, before the sixth German congress for internal medicine,³ advocated the following prophylactic measures against tubercular infection.

It is the duty of the physician to call attention to the danger of intimate relationship with these patients. He must also insist on the greatest cleanliness in the care of the sick, freedom from sexual connection, and unnecessary intimacy. The physician

should speak out boldly against the marriage of the tubercular, and should especially insist on the observance of the rules formulated upon our knowledge of infection. It is more nearly possible to remove the danger of infection on the part of patients in hospitals, and consequently there must be a hospital for consumptives, or a department for them. The state should watch, with the greatest care, cattle suffering from murrain, as there is danger of infection from them; the well cattle should be regularly examined with respect to murrain, and the diseased animals should be removed, and, where it is possible, destroyed. The most careful examination of animals slaughtered, and of the meat put upon the market, should be made by competent medical authorities.

One must seek to prevent the people from forgetting the danger of infection; especially must this be the case with those who are predisposed, though others are also in danger. The nursing of children by tubercular mothers or wet-nurses, as well as kissing and tending by tubercular nurse-girls, should be positively forbidden.

Cerebral Abscess: Its Relation to Disease of the Ear.—Much valuable information has been published about this relationship during the past year. It has tended to modify the knowledge we possessed before, and especially shows that ear disease, in one or other of its forms, is much more frequently the cause of cerebral abscess than is stated by old authorities. The article which has been considered the best for a number of years on this subject, is one by Sir Wm. Gull and Dr. Sutton and contained in Reynolds' *System of Medicine*. In this article, and in one, by Lebert in *Virchow's Archiv*, vol. x., 1856, cerebral abscess was said to be caused by ear diseases in one third of the cases. Among the writers of the present year, much is due to a very able and clear paper by Dr. McBride in the *Edinburgh Med. Jour.*, May, 1887.

The results of the investigations show that although it is still difficult to say with precision from a given set of symptoms in a case of ear disease with head symptoms, what cerebral disease exists and where, yet there have been accumulated sufficient data to make it possible to interfere often and more successfully than ever before.

¹ *Jour. de Méd. et de Chir. Prat.*, July, 1887.

² *Ibid.*

³ *N. Y. Med. Record*, May 7, 1887.

Recent investigators agree that the form of ear trouble which is most frequently followed by cerebral inflammation is chronic otitis media. This is a change from former opinions, which considered inflammation of the external meatus with mastoid disease the more frequent form.

Toynbee, in a paper read before the Medico Chirurgical Society of London in 1851, said the rule of association between the different forms of otitis and the location of the cerebral inflammation was :

(1) Affections of the external meatus and mastoid cells produce disease in the lateral sinus and cerebellum.

(2) Affections of the tympanic cavity produce disease of the cerebrum.

(3) Affections of the vestibule and cochlea produce disease in the medulla oblongata.

But the order of association that now is accepted is the following : Leaving out inflammation of the external canal, the first and most frequent is chronic suppurative middle-ear disease, followed by abscess of the temporo-sphenoidal lobe of the cerebrum. When the mastoid cells are implicated, there may be also abscess of the cerebellum, or thrombosis of the lateral sinuses, or both. And third, when the labyrinth is implicated with the middle ear, the form of intra-cranial trouble is more frequently diffused meningitis.

Here now inflammation of the external meatus is not thought to have any relation as cause to cerebral trouble, and it is no longer thought that ear disease ever causes abscess of the medulla oblongata.

Classifying statistics on this matter of location of intra-cranial disease, Gull and Sutton divide their twenty-seven cases into localized cerebral abscess, nineteen ; diffuse suppuration, two ; cerebellum, six.

Dr. Roosa briefly analyzes thirty-nine cases thus : cerebral abscess, twenty-one ; cerebellar abscess, eight ; diffuse suppuration, one ; clot in lateral or other sinus, eight ; severe meningitis, one.

Dr. P. McBride analyzes forty-four cases :

(1) Caused by disease of tympanum and mastoid, total twenty-eight : cerebral abscess, twelve (three having also diffuse meningitis, and four thrombosis) ; diffuse meningitis usually purulent, six ; cerebellar abscess, two ; thrombosis of lateral or other sinus, eight.

(2) Caused by disease of tympanum

alone, total five : cerebral abscess, three (one sub-dural, one between bone and dura) ; cerebellar abscess, one ; (with pus over roof of tympanum) ; thrombosis of lateral or other sinus, one.

(3) Caused by disease of middle ear and labyrinth, eleven : diffuse meningitis, usually purulent, six ; cerebellar abscess, four ; thrombosis of lateral or other sinus, one.

Dr. A. E. Barker, in discussing the pathology and treatment of cerebral abscess (*Glasgow Med. Jour.*, Aug., 1887), says nine tenths of all cerebral abscesses from ear disease lie within a circle of three fourths of an inch radius, one and one fourth inches above and the same behind the external auditory meatus. He said also that the cause in such cases for the cerebral complication was the chronic obstruction to the free discharge of pus.

Turning now to the symptoms that are suggestive of cerebral trouble, the investigations of the past few months have added much to guide us. They do not yet make us positive in our diagnosis, but the probability is greatly strengthened. First, the symptoms which point towards cerebral abscess are, in order of value, persistent subnormal temperature and pulse. Dr. Barker thinks this is most marked at night. This occurring in a case of chronic suppurative otitis media, with a history of previous cerebral symptoms, is good grounds for expecting encapsulated abscess of the cerebrum. At the same time, with coma or a semi-comatose state, cerebation is slow but perfect, and if bone-conduction be preserved, the location can be confidently set down as the temporo-sphenoidal convolution of the cerebrum. Second, and with more certainty, can one group the symptoms of thrombosis. Following middle-ear with mastoid inflammation, pyæmic febrile conditions appear ; there may be œdema over the mastoid. As the phlebitis extends down the jugulars, these show as tender swollen cords. There may then occur spasm of the sterno-mastoid muscle, and other symptoms due to pressure upon the glosso-pharyngeal, pneumogastric, spinal accessory, and hypoglossal nerves. The fever is of a distinctly remittent type, temperature fluctuates, pulse rate varies, and profuse perspiration and rigors occur at intervals. Thrombosis is frequently associated with both abscess and meningitis. Headache is as prominent a symptom here as in the other forms. The

distinguishing symptoms of cerebellar abscess are : severe occipital headache, distressing vomiting, giddiness, and especially distinctive absence of bone-conduction. As to method of interference, trephining and liberation of pus has been successfully performed four times. Schon-dorff, Tuckenbrod, Gowers and Barker, and McEwen. McEwen also gives the opinion that percussion over the scalp will elicit a spot of tenderness corresponding to the location of the abscess. As to the point of trephining, some difference of opinion exists. McEwen, in the *Lancet*, London, March 26, 1887, penetrated an inch above and half an inch behind the centre of the auditory meatus, making a second opening just at the upper border of the meatus, for the purpose of draining the abscess cavity. Other writers of the present year prefer a point one and one fourth inches above and the same distance behind the external meatus. Greenfield and Caird in their operation trephined two inches in front and one inch above the level of the upper edge of the external meatus, but do not give a clear explanation why they selected this unusual spot. This case may also be added to the number of cases successfully treated. No better summary can be given than the general conclusions ending Dr. McBride's paper.

(1) That in a case of chronic middle-ear suppuration, whether the mastoid region be tender or not, opening the mastoid antrum should not be too long delayed if deep-seated pain in the ear be complained of, and if the general symptoms point to head mischief.

(2) That in advanced cases we should attempt to arrive at an exact diagnosis as to the nature of the intracranial mischief, with a view to operative interference.

(3) That we can in most cases detect sinus phlebitis from the presence of pyæmic symptoms and from local manifestations. Thus, if the lateral sinus be involved, the region of the jugular vein will often be found tender and occasionally corded ; if the cavernous sinus be at fault, we should expect œdema of the retina, and around the eye, perhaps also exophthalmus (for further information on this point I must refer to special treatises).

(4) That having excluded sinus-phlebitis the diagnosis may be said to lie between diffuse meningitis and localized abscess.

(5) That the situation of the intracra-

nial suppuration will probably be behind the tentorium if bone-conduction be lost, *i.e.*, if the auditory nerve is involved. That, in my opinion, this is also more likely to be the case when there is marked inflammation of the mastoid (*i.e.*, its external and posterior part), than when the pain seems only to proceed from the tympanum ; but I have been able to obtain no definite proof of this. The results of aural examination must, of course, be taken together with the general symptoms in localizing the brain lesion.

(6) That the most common seat of localized abscess and starting-point of suppurative meningitis is near the roof of the tympanum.

(7) That we cannot in most cases distinguish positively between localized and diffuse suppuration ; but that in cases where pulse and temperature are subnormal, the probability is in favor of localized abscess.

(8) That the point chosen for opening the skull in otitic cerebral abscess should be just above and in front of the osseous meatus.

(9) That such an operation may save a number of cases of localized abscess, and may possibly benefit some in which the suppuration is more diffuse.

(10) That the propriety of exploring the cerebellar region is not so clear, and that this operation should only be undertaken when the presence of pus behind the tentorium is almost certain. A. T. MUZZY.

THERAPEUTICS.

Peyraud (H.) on the Biological Effects of the Essence of Tansy.—

The injection of two drops of the essence of tansy causes in the rabbit the most sudden and violent convulsions. The convulsive movements are extremely violent. There is grating of the teeth, biting the tongue, salivation—sometimes bloody, blanching of the mucous membranes, evacuation of the bladder and rectum, and rapid, spasmodic respiration.

A slight excitation will excite a spasm, as in strychnia poisoning. The sense of hearing is over-sensitive. Consciousness is apparently not lost. These convulsions last from 50 to 60 minutes and, if the dose of the drug has been too large the animal may die of asphyxia.

During this convulsive period the animal bites at every thing that comes within his reach, even the ground and his own paws. This biting, with the convulsive manifestations, makes the attack look very much like hydrophobia.

After the convulsions comes a period of coma, lasting two or three hours, during which the animal appears insensible to all excitations.

The lesions produced in these cases are subpleural hemorrhages and hemorrhagic infarctions in the liver.—*L'Union Méd.*, Oct. 8, 1887.

Habersmith (E.) on the Use of Pilocarpin Muriatric in Yellow Fever.—Some years ago I had an experience with pilocarpin in beriberi, in the San Francisco Marine Hospital, that caused me to resolve that if ever I came in contact with yellow fever again I would give the drug a fair trial in that disease. The first refugees arrived on July 11th; on the 15th there was a death with black vomit, and another death—a relapse—on the 20th. Neither of these cases afforded fair opportunity for trial, but on the morning of the 16th I found a man, sixty-four years of age, in the beginning of an attack—temperature, 104.3° . I put him between blankets and administered one fourth of a grain of pilocarpin hypodermically. In a few minutes water was pouring out of him. In the course of an hour he had three copious evacuations of the bowels. Evening temperature, 101° ; pulse, 92. Next morning, temperature, 99.4° ; pulse, 80. Evening temperature, 96.1° ; pulse, 72—a fall of $8\frac{1}{2}$ degrees. Next day his pulse and temperature were normal, and he would have left hospital if I had permitted it.

The next case occurred on August 1st, and was a repetition of the first. Surprised and delighted at the success of my experiment, I said to myself, This can not be yellow fever, and reported both cases as malarial paroxysms.

Then occurred a curious incident. I was temporarily absent from the station, and on the morning of August 4th a hospital attendant was taken sick with fever. He was immediately put upon the orthodox calomel, castor-oil, and mustard foot-bath treatment, and developed as perfectly a typical case of yellow fever as ever was seen—spongy, bleeding gums, albuminous urine, fever lasting four days, great prostration, pulse in convalescence as low as

54 beats; and I asked myself what would have been the history of the case had he been treated as the other two men were treated.

I soon had light. On August 12th there arrived, two days from Key West, a family—man, wife, and six children. Parents both sick with fever—taken sick the morning of arrival. I hurried them into hospital and put them under pilocarpin treatment, with the result of having them both convalescent within forty-eight hours. Then a child, aged ten, was taken, on the morning of the 14th. Temperature, 102° ; pulse, 120; administered one eighth grain. Evening temperature, 104.3° ; pulse, 140. Dose of pilocarpin not large enough; repeated it, giving about one third larger dose, causing free emesis as well as profuse diaphoresis. Next morning her temperature was 99.2° , a fall of over five degrees; her pulse, 120. During the day they both became normal, and that was the end of her fever and sickness. Pilocarpin should be used in the first stage, in doses sufficiently large to produce a decided effect—either emesis or catharsis, preferably both. My theory of the *modus operandi* is not that the drug has any specific effect, like quinine in malaria, but that it sets every excretory function in the whole body actively at work, and the enormous flow of water from the skin reduces the fever on precisely the same principle as the temperature of the water in a water-monkey is reduced—namely, by rapid evaporation.

The treatment is thoroughly scientific and rational, the result of much thought and observation, and applicable to the whole range of Southern bilious fevers. They can be broken by pilocarpin, promptly administered; that, followed by quinine, to prevent recurrence, will surprise and delight both physician and patient.

It has long been known that pilocarpin, given at the commencement of an ordinary paroxysm of intermittent fever, would stand the paroxysm on its head, so to speak—that is, it brings the sweating stage to the front, and there is little or no fever. I believe I am the first to demonstrate the great value of the drug in yellow fever; indeed, judging from my cases here, yellow fever becomes a very trifling matter.—*N. Y. Med. Record*, Oct. 8, 1887.

Prevost (J. L.) and Binet (P.) on the Physiological Action of Cytisus Laburnum.—The authors found an

aqueous extract of the seeds, the most active preparation of the plant. By experimentation on animals the authors have found that it has a paralyzing effect on motor nerves similar to that of curare, sensibility being left intact. It proves also to be a central emetic, acting more promptly when given hypodermically than when given by the mouth.—*La France Méd.*, Sept. 29, 1887.

Janvrin (J. E.) on the Use of Aveloz in the Treatment of Cancer.—As a local application, the author prefers it to any other escharotic in such cases of epithelioma of the cervix as are not far advanced, and in which for any reason it has been decided not to extirpate either the cervix or the entire uterus. He hopes that the drug may prove curative in some cases.

In hopeless cases it has proved itself, in his hands, capable of diminishing pain, and diminishing the quantity of the discharge, and rendering it less offensive.—*Annals of Gynecology*, Oct., 1887.

Kennefick (J. S.) on Morphia vs. Calabar Bean, in the Treatment of Traumatic Tetanus.—I was sent for to visit a man who had just recovered from a contused and lacerated wound of the scalp, and found him suffering from the incipient symptoms of tetanus—tonic muscular contractions of the face and neck (especially the sterno-mastoids, which stood out like two tense cords along the neck); pain under the sternum, extending backwards to the spine; inability to masticate; he was, however, able to swallow fluids. I administered a purgative. On the next visit the disease was fully developed, with violent opisthotonos. I prescribed belladonna and quinine, a quarter grain of the former, with two grains of the latter, in pill, every three hours, and a hypodermic injection of morphia, which abated the muscular contractions somewhat. At night I administered another hypodermic injection of morphia, which, in addition to the above good result, produced three or four hours' sleep. The friends of the patient then expressed a desire to have another medical man called in, which was accordingly done, and it was his opinion that the only means of saving the man's life was by large doses of Calabar bean and Indian hemp. Both were prescribed accordingly in large doses every alternate hour, but effected no appreciable improvement.

Being called on suddenly to say the patient was dying, I hastened, and found him suffering from most violent spasms of the muscles of the back, and writhing in agony; I administered another hypodermic injection of morphia, which allayed the symptoms. The effect being only temporary, on the next visit in consultation we agreed to inject Calabar bean subcutaneously, which I did by dissolving one grain of the extract in thirty minims of water, and injecting ten minims for a dose; this was repeated, but without producing any beneficial effect whatever, and the patient subsequently died of asphyxia. In the course of the treatment ice was kept constantly applied to the spine. In this case, the "weight of evidence" appears to me to be in favor of morphia and other narcotic treatment to the exclusion of Calabar bean.—*Med. Press*, Sept. 14, 1887.

Meldon (A.) on the Treatment of Tetanus.—When twenty years ago I first encountered in hospital practice a case of acute tetanus, I sought the assistance of my colleagues in Jervis Street Hospital, only to find that each held a different opinion as to the treatment which ought to be pursued. One thought all treatment useless, a second advised nicotine, a third Calabar bean, and a fourth quinine. In this case, acting on the advice of my colleague and friend, who now occupies the presidential chair of the College of Surgeons, Ireland, I divided the nerve, giving complete relief for the time being; but soon the spasms returned, and death was the result. The drug internally used was nicotine. I have since tried in succession Calabar bean, Indian hemp, curare, quinine, alcohol, and opium. In all these cases the result was fatal.

Some years ago I treated a case with a combination of hyoscyamus, belladonna, and conium. The case was very acute. The symptoms were first noticed on the fifth day. On the second day of the disease the pulse was 120, and the temperature 103°, which alone marked its acute nature, yet under the belladonna, hyoscyamus, and conium treatment the patient recovered. Some months later I had another successful case, commencing on the seventh day.

Out of seventeen cases which I have now treated with these drugs, there were thirteen recoveries and four deaths. These results have induced me to bring forward

this plan of treatment, in the hope that it may be equally successful in the hands of others.

Since the introduction of antiseptic surgery, tetanus has almost disappeared in the Dublin hospitals.

The following statistics of 937 cases which I have collected, necessarily lose a good deal of their value from the fact that a very large number of unsuccessful cases are not published; the fatal cases being so common as to present few features of interest.

No. of Cases.	Treated.	Recovered.	Died.
370	Chloral.	83	289
125	Curare.	23	102
60	Nicotine.	3	57
96	Opium.	4	92
21	Conium.	3	18
76	Cannabis Indica.	12	64
28	Bromides.	2	26
103	Alcohol.	25	78
17	Belladonna, conium, and hyoscyamus.	13	4
41	All other remedies.	17	24
937		185	752

In the above table no case is included which does not seem to the compiler to have been an acute case. All cases where the first symptoms commenced later than the fifteenth day are excluded. All in this table are traumatic—*Med. Press*, Sept. 14, 1887.

Mays (T. J.) on the Physiological Action of Kreatin, Kreatinin, and Their Allies.—At the first glance it seems hardly fair to presume that the animal body should be so profligate as to excrete any substance which is in the least capable of rendering service to its nutritive processes, yet my experiments furnish such strong evidence of the nutritive value of kreatin and kreatinin, at least so far as the frog's heart is concerned, that I am led to treat this as an open question. In all these experiments the original cardiac tracings were first obtained by allowing the heart to beat with a 2 per cent. solution of dried bullock's blood, after which it was worked to complete fatigue with a 0.6 per cent. saline solution, and then the agents under consideration were introduced, and their action on the organ ascertained. Those agents which had the power of reviving the heart are kreatin, kreatinin,

hypoxanthin or sarkin, and xanthin, the two last only in a slight degree; while those which did not possess this power are carnin, inosit, guanin, urea, ammonia, theine, caffeine, and asparagin.

There is quite a marked difference between the action of kreatin and kreatinin, and the other agents which were examined; that the action of the two former is similar to that of blood, milk, etc., in sustaining the heart's action, and hence can no longer be regarded as devoid of nutritive properties. It may be true that they are the products of a destructive metamorphosis, which begins with the albuminous foods and tissues, and ends in urea; but then these experiments show too that their influence as nutritive agents compares favorably with that of a 2 per cent. blood solution, as will be observed on the tracings. Indeed I repeatedly found that after working for many hours with a frog's heart, and after it became so thoroughly exhausted as to refuse to respond any longer to the stimulant action of blood, the transfusion of kreatin, or of kreatinin, in the proportion of one part to one or two thousand parts of saline solution, would at once spur it on to renewed contractions, which were continued for some time longer, thus showing that their power for calling forth cardiac pulsations exceeded that of the blood to a great degree.

In view of the fact that asparagin, theine, and caffeine bear a very close chemical relation to kreatin and kreatinin, to which they are also supposed to be similar in action, it was deemed important to test their influence on the frog's heart; but in no instance were they shown to be capable of reviving the heart's contractions, and hence they must differ in their physiological properties from the two latter agents.—*Practitioner*, Oct., 1887.

Collamore (G. A.) on *Phytolacca Decandra*.¹—In the United States Dispensatory it is described as having emetic, purgative, and narcotic properties. In over-doses, it produces violent vomiting and purging, and even convulsions. It has occasionally caused death, the symptoms being violent purgation followed by coma. It is also classed as an alterative.

Its exact physiological action is somewhat uncertain, but it evidently exerts a

¹ See MEDICAL ANALECTIC, June, 1887, p. 251; also *New Remedies*, July, 1873.

powerful inhibitory influence on mammary hyperemia, probably by its action on the nervous system, especially the vaso-motor nerves. I have never experienced its emetic, cathartic, or convulsive action, though I have frequently prescribed it in full, if not in large doses, but its narcotic effects have been often noticed. It is no uncommon thing for the patient to ask if there was not laudanum, or other opiate, in the medicine administered. As we cannot explain the action of quinine suppressing the malarial manifestations, or of arsenic in affections of the skin, so we must be content to accept the fact of the potent influence of phytolacca in mammary inflammation as a specific action of the drug.

Its remarkable properties in the above-named affection have suggested its use in the inflammation of similar or allied glands, and I now usually employ it in cases of orchitis, or epididymitis, in which cases the pain and tenderness rapidly subside, though, as I use other local remedies, I do not know how much of the effect is to be attributed to the drug in question.

Reasoning from analogy, it would seem that this might prove a useful medicine in inflammation of other glands, as the lymphatic, etc., but I am not aware of its having been employed in that way, unless its use in syphilis may be so construed.—*Columbus Med. Jour.*, Sept., 1887.

Fenwick (E. H.) on Jambul in Diabetes.—My experience is limited to surgical cases seen at the London and St. Peter's Hospital. They are as follows:

Diabetes insipidus.—No diminution of the urine with jambul.

Diabetes mellitus.—Cases presenting themselves with sloughing ulcers of diabetic origin, or accidental wounds in diabetics, refusing to heal under any application or treatment, gave these results: water diminished; sugar decreased; ulcers filling in, and wounds granulating and healing with surprising rapidity. Dose, $2\frac{1}{2}$ gr. to 5 gr. in perles thrice a day after food.

One case in point may be mentioned. A diabetic of eighteen months' standing, who had been lately under strict diabetic regimen and treatment, applied to me for relief of rapidly increasing sloughy ulcers of leg and thigh. These ulcers caused great pain. The patient stated that he filled a full-sized zinc pail with urine every night, and although he did not measure his urine in the day, he believed it was even greater in quantity.

In one week with jambul ($2\frac{1}{2}$ gr. thrice daily) the urine diminished to one half the quantity, and some of the deepest ulcers had filled up and skinned over. Few cases have impressed me so much with the value of jambul in diabetic ulceration as this.—*Lancet*, Oct. 8, 1887.

Hutchings (W. D.) on Gelsemium in Sun- or Heat-Stroke.—I was called early in July, 1878, one day about sundown, to see a young man, aged 25 years, stricken with heat, or sunstroke. The sufferer inside was tossing in violent convulsions on the floor.

I threw twenty minims fluid extract gelsemium into the cellular tissue over the pectoral muscle, and then relieved him of restraint; his violence gradually subsided, and he regained consciousness within half an hour, and one hour afterwards was able to swallow hydr. submur., gr. x; pulv. ipecac., gr. xx; bicarb. sod., gr. x. I then left him, feeling safe as to the result of the emetico-cathartic. The next day's visit found patient completely recovered. No subsequent treatment was required.—*Therap. Gazette*, Sept., 1887.

Hidalgo on Cold Affusion in Apparent Death from Lightning.—Dr. Hidalgo, of Mexico, brought before the Academy of Medicine of that city, at a recent meeting, the case of a man who was struck by lightning, and was at first thought to be dead, but who, after having had, at the suggestion of a passer-by, a large quantity of cold water thrown over him, began to show signs of vitality. He did not at first receive any medical treatment, so that the early history of the case had to be obtained from the relatives. After being brought home, water was still poured over him until he spoke for the first time, saying he was cold, and begging that this treatment might be stopped. He was then put to bed. During the night he did not sleep, but kept talking in a delirious manner, and complaining of pain, especially in the head. When asked what was the matter, he said at one time that he had something the matter with his chest, and at another that he had rheumatism all over, but he made no reference to the lightning. Dr. Hidalgo saw him the next day and found him in a semi-comatose state. The pulse was 75, full and compressible, the temperature normal, the respiration rather rapid. He was so deaf that he could only be made to open his eyes by shouting close to his ear. The pupils were contracted. He complained of

pain all over, but especially in the head and arms. He had passed three badly smelling liquid stools during the night. He was neither hungry nor thirsty. The electric spark had entered the upper part of the right parietal region just behind the auricle. The scalp was burned over a surface of about 4 by 5 centimetres, and a spot of dried blood was seen on the upper part of the auricle. The right side of the neck was reddened as by a burn of the first degree; below this, as far as the umbilicus, the effects were equal to those of a burn of the second degree, of the width of about 15 centimetres at most, but very irregular in its dimensions. The electric fluid had passed down the inner aspect of the right leg, producing a burn of the second degree. It had then passed down to the foot where the burn was of the first degree, and the strip of skin affected much narrower than above. The hat, coat, and trousers were injured—as if torn—all along the course of the current, but they were not burnt in any part. The patient was treated with sedatives and some clysters, and in sixteen days was perfectly well. Dr. Hidalgo supposes that the pneumogastric was affected by the shock, which paralyzed the respiration, and subsequently the heart's action, similarly to the behavior of an overdose of chloroform. The indication, therefore, was to re-establish the respiration, and this was admirably fulfilled by the cold affusion, which fortunately was administered quickly, before the paralysis of the heart had become absolute.—*Lancet*, Oct. 1, 1887.

Hays (J.M.) on Sloughing Following a Hypodermic Injection of Antipyrin.

—It was in the second week of a case of typhoid fever in a lady aged thirty-five. Temperature, 104.5° ; muttering delirium; subsultus tendinum, etc. Antipyrin, gr. xij; aquæ, ℥. xxiv., was injected hypodermically into the subcutaneous tissue of the left arm. All untoward symptoms were promptly relieved, but a slough the size of a silver quarter formed at the point of injection, which was the source of considerable pain and annoyance. The syringe was above suspicion, being in constant use, and never produced an ulcer before or since. In this instance it was quite a surprise to me, as the occurrence of such a result had but recently been denied by the author of an able article on antipyrin. The same drug produced in this case an intense urticarial

eruption.—*N. Y. Med. Record*, Oct. 8, 1887.

Winnett (H. J.) on a Peculiar Effect of Antifebrin.—Early Sunday morning, August 14th, I was called to see a lady suffering with tonsillitis. She was feverish and restless, having slept but little the night previous. Ordered antifebrin in 5-grain doses every four hours. Saw her again in the evening, presenting a cyanosed appearance, lips and finger-nails being a dark blue, and numerous bluish spots about the face and neck; pulse 112 and feeble. She had taken three doses—in all fifteen grains. I discontinued the antifebrin and gave whiskey and digitalis, and the symptoms all disappeared in a few hours.—*Therap. Gazette*, Sept., 1887.

Smith (A. H.) on Cocaine in Dysuria Depending upon Stricture.—“Was called, September 8, 1887, to a case of retention of urine. Found a stricture in the membranous portion of the urethra, which a No. 4 English catheter, the smallest I had with me, would not pass. The urine escaped in drops. Patient stated that for many years the stream had been small and twisted. The day before, he had been exposed to cold and fatigue, and on rising on the following morning he found that he was able to pass his water only by drops.

“Finding that with my smallest instrument I could not get into the bladder, I passed a larger catheter down to the stricture and injected a few drops of a four per cent. solution of cocaine. In about ten minutes the patient was able to pass his water as readily as usual, and quickly emptied the bladder without any further assistance.”—*N. Y. Med. Record*, Oct. 8, 1887.

Kingsbury (G. C.) on Cocaine in Dislocations.—The other day I found cocaine useful in a way that was new to me, and venture, even at the risk of treading ground already covered, to send you an account of the case.

A mason fell off a platform where he was at work, and dislocated his elbow very badly, the skin being so thinned by stretching as almost to let the bones protrude. His pain was most intense, and he could not tolerate the least handling of the limb. Five minims of an eight per cent. solution of cocaine, injected deeply near the head of the radius, produced complete local anæsthesia, and relaxed all muscular tension, so that the dislocation was readily reduced,

absolutely without pain.—*Br. Med. Jour.*, Sept. 17, 1887.

Chapin (A.) on a Cocaine Peculiarity.—I think one peculiarity of cocaine has never been written about in the journals, although it may often have been observed by individual practitioners, and that is its tendency to lose its strength (in solution) after a day or so. I have never taken care to measure the time accurately when it begins to do so (after being made into a solution), but I have noticed for some months back that, unless I get a very small supply of the solution at a time, of the strength which I make use of (four or twenty per cent.), I cannot produce with it the full anæsthetic effect after using the same solution three or four days. The idea suggests itself to me that this is the reason why, when cocaine is accomplishing such brilliant results for some who use it, others find its results often negative, and are therefore inclined to depreciate its good qualities. I make it a practice to get the solution put up in rubber-stoppered bottles, but even then I notice the same tendency of the solutions to lose their strength on standing a few days; so that I confine myself to getting the smallest requisite quantity at a time. When the four per cent. solution is combined with Dobell's solution, it also shows the same peculiarity.—*Letter to N. Y. Med. Jour.*, Oct. 8, 1887.

Atkinson (G. A.) on the Chemistry and Pharmacology of the Nitrites and of Nitro-Glycerine.—The action of the salts of nitrous acid resembles closely those of the acid, which is the essential basis of this group of medicinal agents. Nitrous acid is remarkably unstable; in watery solution of $\frac{1}{100}$ it may be used for a day or two for experimentation, but it has no advantage over a solution of nitrite of sodium, which possesses identical effects in so far as an acid can be considered identical with one of its salts. Our knowledge of the action of the nitrite group has been chiefly derived from a study of the effects produced by nitrite of amyl. Since here the base (amyl) has a decided action of its own, it is necessary to select a salt in which the base in its combination possesses no well-marked physiological activity. The resemblance between the action of sodium nitrite and amyl nitrite has been pointed out by Gamgee, Lauder Brunton, Hay, Leech, and others. Barth describes its highly poisonous qualities. Binz showed

that it caused death from general paralysis, especially of the muscular system, no convulsions preceding the fatal issue. Reichert considered it identical in its toxic effects with potassium nitrite. Its effects may be summed up as a paralyzer of muscular tissue, non-striated muscle being affected less quickly than striated. The brain-centres are also affected, the blood becomes of a chocolate color in mammals (methæmoglobin), respirations are slowed, and temperature slightly lowered. Death occurs in frogs from cessation of respiration; after the heart has stopped its movements it is found in full diastole and quite inexcitable.

Post-mortem rigidity comes on early. In rabbits, three grains were a fatal dose in one three pounds in weight. The same appearances were found *post mortem*. In man, small doses (eight grains) produced great tendency to faintness and considerable acceleration of pulse, with decided lowering of arterial tension. Paralysis of respiration is due to the effect of the nitrite on the muscular system chiefly, but also in part to the effect on the medullary centre. Small doses slightly increase the flow of urine; large always diminish it. Urea and uric acid are almost unaffected. Sugar appears in the urine of rabbits after some hours, if the animal be kept very decidedly under the influence of the drug; but rapidly disappears if the administration of the drug be stopped. The nitrite is largely destroyed in the system, being partly, however, excreted as nitrate, partly, probably, as urea; a portion of it is excreted as nitrite.

The pharmacology of the other nitrite is briefly dismissed. Nitrite of potassium, nitrite of ethyl, nitrite of amyl act in very similar manner to the sodium salt. Nitro-glycerine acts partly as a nitrite, and partly *per se*. In small doses it exerts the nitrite effect as a paralyzer; in large doses it produces convulsions.—*N. Y. Med. Record*, Sept. 17, 1887.

Bazan on the Time of Day to Give Ether or Chloroform.—The author has not experienced any great disadvantage from the use of chloroform or ether, and believes that these could be obviated very much by operating in the early morning. He prefers this time for two reasons: first, because the stomach is empty, and consequently there was less nausea; second, because the brain cells are fresher, and as

recent opinions seemed to indicate that the evil effects of chloroform are due to coagulation of protoplasm in the nerve cells, he thinks a time should be selected when these tissues are as free as possible from fatigue. —*Pacif. Med. and Surg. Jour.*, Oct., 1887.

Carter (A. H.) on the Use of Colchicum in Gout.—From the author's paper the following practical conclusions may be gathered: First, that colchicum should be avoided in all cases attended with debility and cardiac feebleness; and that its use should be confined to early attacks of a sthenic type, and a pulse of distinctly high tension. Also, from the liability to depress the system, and to interfere with renal elimination, its administration should not be continued for a longer period than is absolutely necessary for the relief of pain. In order to prevent the employment of a larger quantity than is necessary for this purpose, it is desirable to give the drug in moderate doses, repeated at short intervals, rather than in a large single dose. In this way, the action may be kept more perfectly under control. Lastly, since there is no evidence to show that colchicum has any curative influence, but rather that, in spite of the relief often afforded, it tends to encourage recurrence, it is safer to avoid its use altogether when possible; and under no circumstances should a patient be allowed to resort to the drug, except under medical supervision. —*Birmingham Med. Rev.*, Oct., 1887.

On Red Wine in "Bed Wetting."

In 1840 a professor under whom I studied in Baden, stated that the physician of an orphan and foundling asylum where children were kept till they had reached their fourteenth year, cured night wetting of beds by red wine, in two weeks. The wine was given at bedtime and in the morning before eating. Fifteen years ago a 62-year old man found himself unable to retain his urine more than five minutes. Recalling the red-wine cure of the orphan asylum to mind I gave him some home-made red-wine (half blackberry, half elderberry), and he held his water for fifteen minutes and then returned for a second dose. Subsequently he was able to hold his water for two hours during a jury trial. I subsequently cured the urinary incontinence of a fourteen-year-old girl with it, and later that of other children. In one case it is said to have failed, but as the child's guardian was a fanatical spiritualistic prohibitionist, it is

doubtful whether the child ever received the remedy. Two old men, one over sixty, one seventy-six, were cured by it. The dose given was for children one to four drachms, and for adults three ounces. The dose given at the orphan asylum was double this of pure wine (port), unobtainable here. A mixture of blackberry and elderberry wine is an excellent substitute. The remedy deserves a trial, as it is certainly palatable. — Letter to *Medical Standard*, Oct., 1887.

Holmes (T. M.) on Nux Vomica for Opium Poisoning.—On June 17, 1887, at half-past one o'clock P. M., I was called to see W. C. B., whom I found apparently breathing his last with alarming stertor. He was in a state of profound narcosis, his face extremely livid, pupils very much contracted, respiration about four or five per minute, extremely deep and labored, while his pulse ran about thirty per minute, quite full and strong. I inferred opium, but, not having known the nature of the case before leaving my office, fully fifteen minutes were lost in securing my stomach-pump and antidotes.

Two hypodermic tablets of sulphate of atropia (gr. $\frac{1}{10}$ each) were immediately given the patient hypodermically, and his stomach was thoroughly washed out several times with an improved syphon stomach-pump. Artificial respiration was kept up continuously by a strong man being astride of his thighs, drawing in the lower portion of the patient's thorax and making quick anterior pressure. This laborious process could not have been kept up as it was for hours if there had been but two or three persons to have executed it, but, fortunately, there was no lack of help. The hypodermic injections of gr. $\frac{1}{10}$ of sulphate of atropia were repeated every three hours until the pupils were well dilated, which required about gr. $\frac{1}{4}$.

Diligent search having now been made, it was discovered that he had bought ten grains of morphine that morning after leaving his place of business. We inferred that he had taken it all. His system was so thoroughly charged with it, the efficiency of the muscles of respiration was so completely overcome, that I suggested testing the efficacy of fluid extract of nux vomica. This preparation had been used in several cases by Dr. A. C. Davidson, of Sharon, Ga., with, as he claimed, the most satisfactory results. Dr. Davidson had used it in such heroic doses as to produce the char-

acteristic tetanic convulsions, etc. In the case of B. we gave one drachm of fluid extract of *nux vomica*, and repeated the dose in three hours. I saw no decided physiological effect from it, but after the second dose the muscles began to respond much more readily to the galvanic current (which had been used from the first with intermissions); a flush came to his face, and the skin became moist. It was now seven or eight hours since our work began. All this time artificial respiration had been kept up, but now the battery (each pole being in the hands of a separate operator), applied to every part of the body, was sufficient to keep up this important function. Indeed, the muscles would now jerk, and writhe, and twist under its powerful influence, and shortly the patient began to groan and turn because of the pain thus produced. About three o'clock in the morning of the 18th, or about seventeen hours after the ingestion of the poison, he responded with a grunt to the call of his name, and in an hour or two he was sufficiently conscious to reply in words. Before twelve M. of the same day he was perfectly conscious, and acknowledged to have taken, at eleven o'clock A. M. of the day previous (two hours and a half before I reached him), the ten grains of morphine with suicidal intent.

For perhaps twenty-four hours after his return to consciousness there was some, though not extreme, opisthotonos as the result of the *nux vomica*. This was the only unpleasant effect of its administration, and since that time the patient has suffered no inconvenience except with his arms. These were nearly paralyzed for some weeks afterward, the result partly, I think, of the numerous hypodermic injections, but mainly due to the flagellations with wet towels. It has been quite six weeks since the occurrence, and the patient is all right. *Medical Register*, Oct. 8, 1887.

Chassaignac (C.) on Extreme Susceptibility to *Nux Vomica*.—The first case was a woman of forty in good general health. A quarter of a grain of the extract of *nux vomica* gave her feelings of impending paralysis. She went to bed much agitated, and complaining of lightness in the head. She lost control of her limbs, and jerked, causing her to fall on the floor, from which she was unable to rise.

The second case was that of a young married woman, who was pulled down by fatigue and grief. We gave her a tonic,

containing one sixteenth of a grain of strychnia to the ounce. She was directed to take one teaspoonful three times a day. The second day after, we were called in haste, to find her in what appeared to be a very serious condition. She was delirious, talking incessantly, complaining of lightness and emptiness of the head; touching the latter she would exclaim: "It's empty; I tell you it's empty!" She showed a slight degree of opisthotonos, had severe contractions of muscles of neck, arms, and legs, which caused intense suffering. During intervals between contractions there was great tremulousness, and she complained of numbness of extremities. Pulse was small and frequent, respiration hurried and jerky. There could be no mistake in the diagnosis, and we looked for the vial of tonic to see if an excess had been taken, but found that less than half of it was missing, so that these symptoms were produced by less than one thirty-second of a grain of strychnia, taken in divided doses. Bromide of potassium and chloral hydrate were administered in good doses every hour. It was only after the second dose that the symptoms began to abate, and only after six or seven hours that she commenced to sleep, and was relieved of the severe symptoms. Next day she still had slight muscular twitchings, and some numbness and soreness of the extremities. — *New Orleans Med. and Surg. Jour.*, Oct., 1887.

Wilcox (R. W.) on Apomorphia in Respiratory Diseases.—I have used apomorphia chiefly in acute bronchitis. In those cases with considerable frontal headache, hot, dry skin, sore throat, marked prostration, rapid pulse, high temperature, stuffy feeling in chest and soreness in epigastrium, dry teasing cough; when physical examination shows harsh respiration, sonorous and sibilant râles with few coarse and fine mucous râles, are its effects most marked. Here, if one thirty-second to a forty-eighth of a grain be given every two or three hours one finds the headache relieved, the sore throat has disappeared, pulse and temperature fall, the cough is markedly diminished in frequency, and a copious watery expectoration, easily raised, is coughed up; the respiration becomes softer, the dry râles disappear, and many moist râles are heard. In order to procure a good night's rest, acting upon the suggestion of Dr. M. R. Vedder, I now give with

each dose a small quantity of the bromides, preferably that of potash. The first daily dose of the apomorphia mixture is taken upon awakening in the morning; resting quietly in bed for a few minutes, a glass of warm milk is taken; in a short time a full breath is followed by a series of coughs by which the night's accumulation of mucus is dislodged and expectorated. Generally there is very little coughing during the day.

The prescription, which may be varied according to each case, is :

B		
Apomorphinæ	gr. ss	ad j
Potassii bromidii	3 ss	
Tincturæ sanguinariæ	3 j	
Syrupi tolutani	q.s.	ad 3 iv
M. et. ft. sol.		

S.—Teaspoonful every two or three hours in a wineglass of water.

The sanguinaria is added for the benefit of the apothecary, showing him that it is a cough mixture; otherwise he would alarm the patient by telling him that it was an emetic,—a circumstance that has happened more than once.

This prescription, modified according to circumstances, can be used in pneumonia, phthisis, chronic bronchitis, and spasmodic laryngitis. It is said that this drug is also useful as a spray in relieving the dry throat of phthisis. Failures will occur in the use of apomorphia, as with any other drug, but I have found it to be due to the use of old specimens or of those solutions which have become decomposed and show quite green.

I am sure that any physician who will totally abandon the use of opiates in the treatment of respiratory diseases, use apomorphia and the bromides where indicated, and in the manner above described, will obtain results in a shorter time and far superior to any he has hitherto obtained or can obtain in any other way at present known to medical science.—*St. Louis Med. and Surg. Jour.*, Oct., 1887.

Casson (J. H.) and Brownen (G.) on a New Method of Employing Iodine for Antiseptic Purposes.—The deodorizing properties of iodine have been long known, and although it has for very many years been employed for that purpose in the cancer wards of the Middlesex Hospital, and probably in many other similar institutions, its employment as a general disinfectant has been greatly lessened, owing to the difficulties experienced in its

regular and gradual vaporization. Combined, however, with salicylic acid we find that it can be readily and permanently incorporated with fats, paraffins, or wax, and when candles made from these hydrocarbons thus treated are ignited iodine and phenol are evolved in a gaseous vaporized form. The phenol is produced by the decomposition of the salicylic acid, and its amount varies according to the temperature or rate of the combustion. Its presence may be verified by passing the vapors of the combustion through dilute nitric acid, and thus producing trinitrophenol or picric acid. But where the combustion is rapid and complete the phenol is entirely destroyed, as all other *organic* materials, such as eucalyptus, which has been suggested for somewhat similar treatment, must necessarily be. It is not so, however, with regard to the iodine. Being *inorganic* it is wholly volatilized and thrown out as vapor into the surrounding atmosphere, but it is in no sense destroyed. Its presence in the gaseous products of the combustion may be demonstrated by passing them through a solution of starch, or along a tube moistened with starch mucilage. In either case the iodide of starch is speedily produced, and may be recognized by the usual tests. A very faint odor of iodine may be detected when these candles have been burnt in quantity in a close atmosphere; but this is never unpleasant, or in the least degree irritable to breathe; indeed, in several cases of asthma, spasmodic cough, and "hay catarrh," the patients have experienced great relief from the iodine vapor thus liberated. As a deodorizer its action is most marked; the smell of tobacco smoke is quickly and entirely destroyed by the combustion of these candles in the smoking-room. The air of stuffy rooms and smelling closets may be rapidly purified by the same means. The odor of sulphuretted hydrogen and of ammoniacal air from a close stable have been very speedily and completely discharged by contact with the same vapor.—*Medical Press*, Oct. 5, 1887.

Jones (H. M.) on Antiseptic Cigarettes.—Some few years since I had prepared some cigarettes of iodoform, carbolic acid, and chlorate of potash, for fumigation of the naso-pharynx, the basis of which was powdered eucalyptus leaves with some iodol leaves added. Of these I found from experience the iodoform was the most useful, the chlorate of potash did not ignite or

draw well, and the carbolic acid were not sufficiently strong. The iodoform cigarettes labored under the disadvantage of the characteristic odor of the drug being diffused when they were smoked. After some experiments with various bases and quantities, I have had prepared for me four different forms of medicated cigarettes :

No. 1, containing eucalyptus and iodoform disguised with vanillin.

No. 2, eucalyptus with iodosalicylic acid.

No. 3, coltsfoot with eucalyptus and iodoform disguised with vanillin.

No. 4, tobacco, eucalyptus, and iodoform disguised with coffee.

Each cigarette contains one grain of the active ingredient.

I may mention that the iodosalicylic acid has not the unpleasant odor of iodoform and other iodine compounds. While it is quite as effective on the lower forms of life, under combustion iodine is evolved. All the cigarettes will be found pleasant to smoke, and the odor of the iodoform well disguised ; whilst its presence in the nasopharynx for some time after the cigarette is used may be detected by its taste. Those made with tobacco, eucalyptus, iodoform, and coffee, are particularly agreeable, and the odor is thoroughly disguised ; so, indeed, is it with those made with vanillin, and the coumarin yielding an aromatic vapor which is pleasant rather than otherwise. Half a cigarette is sufficient to smoke at one time. Three in the day are not too many, though the number must be regulated by the prescriber.—*Med. Press*, Sept. 7, 1887.

Filleau and Petit (L.) on the Treatment of Phthisis by Hypodermic Injections of Phenic Acid.—The authors have performed many experiments to test the viability of the tubercle bacilli in the presence of various reputed germicides. They have tested aniline, eucalyptol, thymol, iodoform, sulphurous acid, and phenic acid, and find that phenic acid alone renders a culture-fluid infertile to tubercle bacilli ; a 3 per cent. solution is necessary for this purpose.

The authors favor the hypodermic method of giving the drug. They dissolve the pure acid in sterilized oil, or liquid vaseline, in about the proportion of 1 to 40 or 1 to 20.—*La France Méd.*, Sept. 8, 1887.

Garcin on the Treatment of Phthisis by Inhalations of Hydrofluoric Acid.

—According to the author, the results of this treatment are most happy. The patient must stay an hour each day in a cabinet holding six cubic metres of air saturated with the acid. Of 100 cases experimented on, 14 remained stationary, 41 improved, 35 recovered, and 10 died.—*La Tribune Méd.*, Sept. 25, 1887.

Greene (G.) on Creosote in Erysipelas.—I was called to see a woman, æt. 60, who was suffering from cellulocutaneous erysipelas of the arm and side, and having adopted the usual routine measures (viz., tr. ferri perchlor. internally, and flour, etc., externally), without success, I made a lotion of creosote (10 gts. ad $\frac{3}{4}$ j. aq.), and directed a cloth soaked in it to be wrapped round the affected parts ; but the pain produced was so intense that I was obliged to have it removed in ten minutes, the patient stating that if she were to die in twenty-four hours, and this application would save her life by being left on for twenty-four minutes, she could not bear it even for that short time. Thinking that the pain was perhaps somewhat exaggerated in this instance, I adopted the same treatment in a case of phlegmonous inflammation, of a sthenic type, occurring in an adult male, æt. 30, but had to discontinue it for the same reason as above cited. In both patients the parts became much more inflamed after the application. I have not yet tried creosote in the simple cutaneous form of the disease, and for obvious reasons hesitate to do so. I have, however, recently given it internally in minim doses, repeated every third hour, with the result of considerably lessening the febrile symptoms. Dr. H. F. Foy makes no mention of its internal administration, although he strongly recommends its outward application (*vide St. Louis Medical Journal* for May, 1886). Creosote, therefore, though literally "the life of the flesh," evidently does not (topically speaking) act as its balm in erysipelatous affections. I may add that the second patient was not previously subjected to any other treatment.—*Med. Press*, Sept. 28, 1887.

Klotz (H. G.) on a Compound Salicylated Plaster.—After several experiments, Mr. Rutenik has found the following formula to give the best mass :

℞ Emplastri diachyli simplic.,	}	aa 40 parts.
Emplastri saponati,		
Petrolati		15 "
Acid. salicylic.		5 "

Several years' experience has proved the value of this formula, which, about two years ago, was added to the list of remedies regularly prescribed in the German Hospital and Dispensary of New York. For use in certain cases, a ten per cent. plaster of the same composition has been prepared. This plaster, to which I propose to give the name of the compound salicylic plaster—*emplastrum salicylicum compositum*,—is of a yellowish-gray color, has no particular smell, and, while fully retaining the qualities of a plaster, is soft enough to be spread readily on linen or muslin by any one not entirely inexperienced in this work. It is most useful in the treatment of eczema and chronic ulcers of the leg.—*N. Y. Med. Jour.*, Sept. 17, 1887.

Bulkley (L. D.) on Infant Feeding, Especially with Reference to Subjects with Infantile Eczema.—The author concludes:

1. The necessity of carefully watching the diet of infants with eczema, and giving special instructions that harmful articles may be avoided.

2. Specific instructions in regard to food and its preparation for these cases.

3. The more free use of milk, both for nursing mothers and for infants, deprived of breast milk.

4. The taking of milk by adults, apart from all other food in the interval before meals, when an alkaline state of the stomach facilitates its immediate absorption.

5. The more free employment of wheat products in the nourishment of older children with infantile eczema.—*Four. Amer. Med. Ass'n*, Oct. 15, 1887.

Eliot (L.) on Persistent Vomiting of Labor Arrested by Tincture of Iodine.¹—M——, white, aged 26, born in the District of Columbia, went into labor with her first child March 2d, at 2 A.M. Her previous history was negative, if we except the usual vomiting attending the earlier months of her gestation. When called, at 3.30 A.M., the os was dilating, vagina moist, head presenting, membranes intact, but she was vomiting persistently. Previous to my arrival she had been given lime-water, pepsine, brandy, ingluvin, and cerium oxalate, without benefit. Mustard was ordered over the pit of the stomach, and cerium oxalate,

combined with ingluvin, given without success. Carbolic acid, in half-drop doses, failed, as did lactopeptine. She was becoming rapidly exhausted, and the pains had ceased. Whether to administer chloral hydrate per rectum, or to administer an anæsthetic, and so terminate the labor, were questions to be weighed, when the iodine treatment came to mind. Following the advice of Dr. H. B. Hemenway,² in protracted labors—"Posture during Labor,"—she was propped up in bed, hoping thereby to precipitate the labor, at the same time the finger being introduced and pressed against the anterior lip of the cervix; contractions of a feeble character followed, still the vomiting continued. At this juncture she was given five drops of tincture of iodine in a tablespoonful of sweetened water; the effect was magical, for the vomiting ceased almost immediately. To make assurance doubly sure, she was given a second dose in thirty minutes. The labor now progressed rapidly, and at 5 o'clock, three hours after the first pains, she was delivered of a male child, well developed and healthy. The third stage was normal.—*N. Y. Med. Record*, Sept. 24, 1887.

Squibb (E. R.) on the Oil of Wintergreen (Oil of Birch) as a Therapeutic Agent.—From the private history of the distillation of these oils for the market at the present time, it is very doubtful whether a specimen of true oil of wintergreen can be found.

It should be understood that the element of value in the oils is methyl salicylate, and therefore that the comparative value of the oils will be proportionate to the methyl salicylate each may contain. The dose of oil of birch, like so many other therapeutic agents, varies much in different individuals, and no one can be sure that it has accomplished all that it is capable of doing until it is pushed to its physiological effect upon the individual under treatment by it. Like other salicylates, it is rapidly eliminated, and therefore should be given from four to six times in the twenty-four hours in proportion to the severity of the case. Given in sufficient quantities in this way, it will, in twenty-four to forty-eight hours, cause a ringing in the ears; and this is the physiological effect to be sought;

¹ See Gaunt, Thomas J., *Amer. Jour. Med. Sci.*, April, 1883, p. 413.

² Hemenway, H. B., *Amer. Jour. Obstet.*, June, 1886, vol. xix., p. 575.

and when found, a slight reduction of dose from that which caused the ringing will be the proper effective quantity.

Doses of 10 minims, four or six times a day, will produce the ringing in some individuals; but if not, it should be increased by 2 minims in each dose until the ringing is obtained. In this way, doses of 15 minims will rarely have to be exceeded; then a reduction of 2 minims will give the regular dosage to be observed.

The use of a minim pipette avoids all irregularity. It is a convenient and inexpensive instrument, and is sufficiently accurate for all ordinary dosage.

There are two good ways of administering oil of birch. One is, to deliver the dose into a four-ounce vial containing about two fluid-ounces of cold water, shake the mixture actively, and then pour it into a glass and swallow it while in suspension in the water. The other way is to deliver the dose upon half a teaspoonful of powdered sugar in a glass, add about two fluid-ounces of water, stir actively, and swallow at once, while the oil is in suspension. The dose is not a very disagreeable one, and does not seem to cause disgust nor anorexia by frequent repetition.

In cases in which cod-liver oil is also indicated, it is very good practice to give them together. The strong flavor of the oil of birch entirely covers the fishy odor and taste of the cod-liver oil, and the latter oil agreeably dilutes the birch. Ten or 12 minims, in half a fluid-ounce of cod-liver oil, swallowed after a mouthful of ice water will offend very few palates or stomachs.

The oil of birch does not appear to be a proper alternate or substitute for salicylic acid, or sodium salicylate, in severe cases of acute articular rheumatism, since it does not appear to relieve the pain nor reduce the temperature as promptly; and this might be expected from the circumstance that, when pushed to its physiological effects, it disturbs the hearing and sight less promptly, and in an inferior degree. It seems to be most appropriately used in the milder attacks of gouty rheumatism, or rheumatic gout, which are so much more numerous, and which so often are the cause of protracted suffering and disability. These cases occur in hundreds, and the physician who can relieve a hundred of such is of more use to the community than one who makes a successful laparotomy, and more rapidly gets a better reputation;

and besides he does more,—much more, in combating quackery and pretence.—*An Ephemeris*, etc., Oct., 1887.

MEDICINE.

Musser (J. H.) on the Treatment of the Final Stages of Phthisis.—For the relief of erythema from pressure and moisture, remove the cause if possible; apply astringent lotions and drying powders. The extract of hamamelis diluted, or the aqueous extract of the shops; borax and alcohol; the latter alone; sulphate of zinc, twenty grains to a pint of water; alum and water; carbolic acid (ten drops) in water (Oj); or alum and alcohol, carefully applied, is grateful and remedial. Starch, rye flour, fullers' earth, oxide of zinc, subnitrate of bismuth, iodoform, and starch, are drying powders, named in the order of cheapness, that are efficient. For painful erythemata, iodoform, oxide of zinc, and subnitrate of bismuth with starch in combination, answer well.

Iodoform	1 part.
Zinc	2 parts.
Bismuth	2 parts.
Starch	4 parts.

A saturated solution of iodoform in ether, applied every day, or every other day, seems to relieve pain and remove congestion. A mixture of iodoform and surgical collodion relieves pain quickly. One must not forget the conventional soap-plasters, while glycerine, applied frequently, is also of service. Ointments of iodoform, or of zinc, with the extract of opium or belladonna, are often necessary. For bed-sores, remove pressure, and apply, by dusting, iodoform, Peruvian bark, oxide of zinc, or subiodide of bismuth. Oakum saturated with balsam of Peru is often excellent. Surgical principles will guide in the treatment of exceptional ulcers.

Oedema of the legs is frequently most distressing; bandages and elevation of the limbs are required. The swollen legs are the seat of a very painful erythema; here again, sedatives, as laudanum, and lead water, or hamamelis, are required. One of the easiest prepared and most soothing applications for any oedematous erythema, is the so-called starch poultice—ordinary starch mixed with water to the consistency of thick cream, spread on linen and applied.

Apart from the usual pains in the tho-

rax, the patient suffers from general aching and soreness, and from local areas of pain. Rubbing with stimulating applications, alcohol, soap liniment, arnica, chloroform liniment, or with dry heat or applying hot flannels, are necessary. Local pains may be relieved if in the course of the nerves, or in the extremities, or where undue pressure has been exerted, by cannabis indica; laudanum may also be used, but is inferior in value; lanoline is a good vehicle for any substance. Plasters are not generally pleasant; belladonna, opium, and soap may be selected.

Chest pains are usually severe. Use dry heat, by means of hot cloths, hot plates, or hot-water bags, or sinapisms, or rubefacient liniments. Pain in the epigastrium and about the heart often occurs in the last week, and is most horrible; dry heat is the most serviceable of external applications. The pain appears to be due to tension on the adherent pleura, by collapsing or contracting cavities. The secret of success in the treatment of the general and local pains, is the ability to ring the changes on various articles; the wrought-up nervous system conjures up or intensifies pains, which require an agile mind to relieve.

For the dry, parched; or fevered lips, use cold cream; camphorated or benzoated oxide of zinc; camphor water and glycerine, with or without borax, or boracic acid; or even glycerine alone, may be used. An erythematous stomatitis is often present; demulcents are required. Decoctions of marsh-mallow, or gum arabic, are soothing; morphia, or the syrup of poppies in a demulcent, relieves the burning distress. The slippery elm bark of boyhood days, chewed, furnishes a soothing coating to the mucous membrane. The burning that attends erythemata may be relieved by allowing bits of borax to dissolve in the mouth, or by applying boracic acid locally. Ten grains of the latter to a half ounce each of water and camphor water are sufficient. Alkaline waters iced are grateful.

For ulcerative stomatitis and thrush, phenol sodique, Dobell's solution, and Listerine, either of them well diluted, are detergent, and often soothing. If the ulcers are few, iodoform in ether touched on them will quickly heal. Boracic acid and camphor water in distilled water is a cooling mouth wash; myrrh is commonly used by the laity. Alcohol in water can

be used; a solution of the bichloride of mercury (1 : 1000) in iced water seems to be cleansing. Flatulency is a most distressing cause of suffering. External applications of heat, dry or moist, are required. The aromatic spirits of ammonia, spirits of chloroform, Hoffman's anodyne, brandy and lime-water, creasote and charcoal in pill, with or without pepsin, or a mixture of carbolic acid, tincture of cardamon, and bicarbonate of soda, with mint water, most frequently relieve it. The recent preparations of pepsin, and pancreatin, are of inestimable value. A bitter before eating, with or without an alkali, prevents a succeeding flatulency: either nuxvomica, gentian, or quassia.

Vomiting arises from laryngeal irritation, from cough, from exhaustion, from local gastric irritation, by food undigested undergoing fermentation. Remove the laryngeal irritation by the local application of astringents and anodynes, by glycerite of tannin with or without morphia, or by astringent and anodyne lozenges. The vomiting of food by cough is prevented by administering morphia half an hour before meals, or by taking deodorized tincture of opium before the meal. The vomiting that occurs after rising is often prevented by taking some stimulant with nourishment, before assuming the erect posture; sherry and egg, or milk and brandy. The vomiting and retching that occur from excessive coughing is to be relieved by the anodyne that checks the cough; the more simple the anodyne the better; minute doses of morphia, if not contra-indicated, are the best. The vomiting of exhaustion is controlled by stomachics, as quassia, or gentian in infusion; by stimulants, as champagne, brandy, and aromatic spirits of ammonia. Vomiting due to local irritation and congestion, caused by undigested and fermented food, is relieved by antifermentatives—carbolic acid, creasote, bismuth, and charcoal; by artificial aids to digestion, by the use of peptonized or pancreatized foods; by alkalies, as iced lime-water, or Vichy water, which act as local sedatives; by carbonic acid water, the effects of which are sedative. The stimulating effect of a sinapism, or the sedative effect of a blister, must be invoked by their respective indications. It must not be forgotten that lying on the right side increases the tendency to vomit, lying on the other side having an opposite effect.

Pain in the epigastrium, a most common symptom from flatulency, from an irritated congested stomach, from a diaphragmatic pleurisy, is to be met by treating the respective causes. A gastric sedative, as subnitrate of silver in pill before meals, with a minute dose of opium, prevents the pain that ensues after food.

Diarrhœa, if colliquative, may be controlled by stimulants, as burnt brandy, ammonia, or camphor; if tubercular, by large doses of astringents. Bismuth, from thirty to sixty grains in each administration, has served the writer as well as any combination of drugs. Logwood is a most valuable astringent, the fluid extract being used most frequently.

Intestinal flatulency is often the cause of diarrhœa, and can be prevented by salicylic acid, by antifermentatives, and by pancreatin. The diarrhœa that follows immediately on taking food is treated by an opiate; preferably deodorized tincture of opium in small doses, five to ten drops, or the powder, one twelfth of a grain, with silver or bismuth, before meals. A septic diarrhœa ensues also in this last stage, and is to be checked by salicylic acid, by naphthol, or other forms of the naphthaline series recently introduced into therapeutics. The diarrhœa of amyloid diseases can only be controlled by opiates.

To relieve the cough of the last stage is most difficult. Dryness of the upper air-passages is most distressing, and local applications are generally painful. By the aid of a mirror, suitable remedies, always demulcent in character, can be applied to the congestive areas about the larynx and epiglottis. Glycerine applied with a brush relieves the dryness; Dobell's solution thus applied is of service. The applications must be made often to the dry areas. Listerine with glycerine is of much value. Inhalations of terebinthinated vapors, or of simple aqueous vapors are most grateful. The simplest form of inhalation is the best. We frequently have generated the vapor in a sick cup, covering the top, and inhaling by the mouth-piece. The ineffectual efforts to cough can be aided by hot water, by hot water and brandy, and by the aromatic spirits of ammonia well diluted. Hydrocyanic acid has never been of any service in my hands for cough, while opiates are to be used with caution. A moderate dose of morphia may produce serious and even fatal symptoms. Codeia has disap-

pointed the writer. Hyoscyamus and belladonna frequently add to the distress by producing dryness of the fauces; to relieve the dyspnœa, our utmost efforts are in demand. Ammonia, alcohol, Hoffman's anodyne, and draughts of hot water are required in turn; external heat contributes to the relief. One of my professional friends says he has seen the air-hunger relieved by quebracho. Inhalations of oxygen should be theoretically of much service; the writer has never used them. The patient must be supplied with fresh, cool air, a source of relief to the distress. Attacks of dyspnœa, of course, are increased by flatulency, and this complication must be removed.

Hemorrhage in the last stage is usually profuse. A knowledge of the pathological anatomy of the lung at once shows the futility of astringents. Rest and opiates are essential, stimulants may be required; ice or cold cloths over the chest are imperatively demanded if it persists.

Laryngeal and faucial tuberculosis increases the distress of the patient. As long as feasible, cocaine to render the taking of food possible must be applied to the ulcerated pharynx and larynx. Insufflations of morphia alone, or with iodoform and starch, must be practised, and over the larynx frequent fly blisters applied. One eighth to one quarter of a grain of morphia, with one grain of iodoform and three of starch, insufflated, or added to treacle and retained by the patient as long as possible in the larynx, gives much relief.

In the late stage of phthisis some means must be used, but not as imperatively as in the earliest stages, to combat fever. Quinine frequently aggravates nervousness, and is inadvisable. The salicylate of sodium, doses of five grains, guarded with a drachm of whiskey, every three hours, is a reliable antipyretic. It is also of much service after the manner of administration by Jacoud. The general restlessness and nervousness which ensue at this period of phthisis must be prevented or allayed by quiet in the surroundings, by free access of pure air, by the administration of light liquid food only, and by the use of stimulating anodynes, preferably Hoffman's anodyne; for a similar purpose, valerian and asafoetida, by the mouth or rectum, or, if practicable, musk can be used; they are of much value. Gentle frictions allay restlessness, while ministrations with soft voice

and gentle action allay an easily perturbed, nervous system. By means akin to these, we can truly administer to the sufferings of our patients. It is quite certain, however, that the firm voice, the truthful countenance, the inspiring touch, sustain and soothe in this trying passage through the valley of the shadow of death.—*Medical News*, Oct. 15, 1887.

Smith (R. S.) on the Treatment of Phthisis by Intra-Pulmonary Injection.—In consequence of the proved utility of iodoform in chest disease, as shown by a steadily increasing mass of evidence since its first introduction for this purpose by Professor Semmola, in 1878, and supported by a series of cases presented to the International Congress of 1884, in which the author found increase of weight, improved appetite, diminution of temperature, and general improvement under the administration of iodoform given by the alimentary canal, it was thought that iodoform would be the best substance to employ for injection into the parenchyma of the lung. The clinical utility of iodoform being the ground on which its use for this purpose has been founded, the evidence is not shaken by any statistics as to the comparatively feeble powers of the drug as a germicide.

The insolubility of the drug is the chief difficulty; various solvents have been used, but with only partial success. Ether is objectionable, because of its effects on the brain; giddiness and other feelings of discomfort rather alarm the patient, and give rise to an unwillingness to have a frequent repetition of the injections. Eucalyptus oil is irritating; two cases were mentioned in which acute pleuritis, with much pain, rise of temperature, and effusion had followed the injection of an iodoform solution in oil of eucalyptus. The vaseline oil, either alone or in combination with eucalyptol, had also been used, but the author still considers the question what is the best fluid to inject, to be still unsolved. He did not advocate the use of solutions containing free iodine or bichloride of mercury, and he would not in future employ any fluid for injection into the lung which had not previously been tested hypodermically; if it gave rise to much inflammatory irritation in the subcutaneous cellular tissue, he would not venture to inject it into the lung. He was of the opinion that injections into cellular tissue, might possibly be of some little service, although there

was as yet not much reliable evidence on this point, but they would serve as a reliable test whether any given fluid was suitable for deep intra-pulmonary injection.

It is true then if iodoform be of use, as the clinical evidence indicates, then it is likely to be of far greater utility when injected, even in small quantity, into the focus of a diseased patch, than when given in larger doses diffused throughout the whole body. Such injections have been shown to be not especially hazardous. Even the cases in which pleuritis has occurred had recovered completely from the attack in the course of a few days, and possibly the pleuritis was due to the failure of the fluid to pass beyond the pleural cavity into the lung-substance. Nevertheless, the author would not advocate the use of such injections in cases which were hopeless, neither would he employ them in cases where other and less active measures were accomplishing the object in view. He concluded his paper by urging perseverance in spite of failure, and by expressing his belief that what as yet was only a tentative investigation would ultimately result in numerous and signal successes.—*N. Y. Med. Record*, Sept. 17, 1887.

Marfan (A. B.), on Hemiplegia in a Child of Five Months with Syphilitic Parents.—The father of the child contracted syphilis six months before marriage. Three or four months after marriage the wife presented herself with a hard chancre of the lower lip. The husband put his wife on his own medicine, iodide of potassium and in nine months she gave birth to an apparently healthy boy. A month after birth, however, ulcers appeared on the baby's legs. These sores yielded to appropriate treatment, leaving, however, characteristic scars. Two years later another child was born, and presented a pretty healthy appearance. When about five months old the child had a fall, less than two feet, which apparently was harmless, as the child did not cry and exhibited no marks of external violence. Eight days later the child manifested symptoms of complete left hemiplegia of a cerebral type, which completely disappeared under specific treatment.—*Ann. de Dermat. et de Syph.*, Sept. 25, 1887.

Shaw (W. C.), on a Case of Slow Pulse.—At a meeting of this society (Allegheny County) Feb. 21, 1882, I reported the case of an old lady about 90 years of age,

whose normal pulse was 36 beats per minute.

Allow me again to report a case of slow pulse which came under my observation May 22, 1887, which for a few hours gave me considerable uneasiness, in which the pulse was as low as 18 beats per minute, and not over 21 beats per minute for two hours in succession while I was continuously at the bedside.

Case.—John Murphy, aged 19, native of United States. Patient had been in his usual health till May 19, 1887. Then he began to feel an occasional pain in one or more of his joints, and was slightly costive. On Saturday, May 21st, he obtained a seidlitz-powder at the drug store, and took it on going to bed. As it had not moved his bowels in the morning, he stopped at the drug store and purchased rochelle-salts and took them. At noon, not desiring other food, he partook of some lettuce, dressed with sugar and vinegar, with hard-boiled eggs sliced over it. Says he took very little of this. Shortly after eating he began to purge and vomit profusely, making him very weak. He finally fainted, and recovering his senses but not his strength, he lay on the floor, able to hear his brothers and sisters talking downstairs, but with not enough of strength to make himself heard, either with his voice, or by attempting to rap on the floor with the heels of his slippers. He described his dyspnœa while lying there as exceedingly distressing.

His brother accidentally stumbled over him after a considerable period had elapsed. I was then hastily summoned at 5 P.M., and on my arrival found him quite weak, with a pulse ranging from 25 to 27 beats per minute. As there was a vial containing spirits of ammonia in the house, I ordered it to be applied to his nostrils occasionally, and to keep his head as low as possible. Mentioned the use of brandy in minute doses, diluted, internally, as he was retching considerably, showing great gastric irritability. His family objected strenuously to the use of alcoholic stimulants, as well as he himself, and as he was suffering much from attempts to vomit, I did not insist upon this. Ordered a mustard plaster to be placed over the stomach, and left the patient, thinking he would recover shortly.

At 8 P.M. the same evening I called again and found the patient weaker than

ever, but suffering no pain anywhere. Pulse 21; respiration 36. The efforts to vomit had been relieved for some time, but were returning. His only desire was to be let alone that he might sleep, which to my mind would have been the sleep of death. I ordered the following prescription: *B.* Spts. ammoniæ aromat., syr. zingib., aa $\frac{3}{4}$ i. *Misce.* S.—A teaspoonful every half hour with a little brandy. Also ordered this to be followed fifteen minutes later with a teaspoonful of lime-water. I injected diluted brandy hypodermically into each arm and over the stomach. Ordered the mustard to be replaced until the integument was quite scarlet.

Remained with him until 10 P.M. During this period of two hours his pulse was as low as 18 beats per minute, and at no time higher than 21 beats per minute. Before 11 P.M. it had reached 40 beats per minute, as taken by the priest, who called just after I left.

My object in having him aroused every fifteen minutes through the night was, to be sure of preventing total collapse, as well as to stimulate him.

May 23d, 10 A.M.—Found him sitting in an easy chair, still suffering no pain. Pulse 45. Ordered the treatment continued, and an equal portion of milk to be added to the lime-water. Ordered also two one-grain doses of calomel with bicarbonate of soda through the day, to be repeated in three days.

May 24th.—Pulse 72. Stimulants discontinued. Feels quite weak yet, but is improving. Visits discontinued.

Patient had been a sickly child for the first two years. Had typhoid fever a few years ago, but had fully recovered, and though never extra-vigorous, had otherwise enjoyed good health. The slight rheumatic pains which he had experienced before the day of greatest distress had all disappeared on the 24th. As slow pulse is sometimes associated with endocarditis, and other lesions of the heart, I was afraid, at the beginning, that he might have such a complication. However, I am inclined to regard the slight pains felt in the joints as indications rather of his bilious condition, than of genuine rheumatism.

I think his slow pulse was due to syncope produced by collapse from his purging and vomiting, and report the case especially on account of this extreme slowness. It was interesting also to note the

fact that, when the pulse was so low, there were two respirations to each beat of the heart. Though interesting as a fact in the history of the case, it was almost painful to mark the long interval between the heart-beats, which in every other respect seemed unusually strong and distinct in character.—*Pittsburg Med. Rev.*, Sept., 1887.

Jessop (C. M.) on Latent Rheumatism.—Concerning this class of cases, the author says: "The pains which young people, especially girls, complain of in the left breast are generally treated with scant consideration, being referred to indigestion, hysteria, or rheumatism, for which no particular treatment or examination is required, because there is no particular appearance or sign of active disease. It has often occurred to me that there was something of more serious import underlying this condition, and that the seat of discomfort was not duly examined from motives of delicacy; and, also, because in young girls or women both glands at a certain age take on a hyperæsthetic condition. In the cases to be detailed the pain was confined to the left breast, and had nothing to do with the gland, for when the gland was moved bodily there was no pain; pain was only elicited when digital pressure was employed between the ribs beneath the gland, chiefly below the apex-beat and to the left. Besides this pain there were also 'fleeting pains' in one or more of the joints, so slight as to be forgotten until enquired for—even then not always remembered distinctly. The urine had not always been noticed, and might or might not be high-colored. As a rule, no feverish condition was complained of, but generally constipation; and *bruit de diable* was always present. Occasionally palpitation and shortness of breath. Menstruation not always normal."

The pain and tenderness are often located in the costo-sternal articulations, the dorsal spine, and the occiput. The patients are what would generally be called anæmic, suffering from dyspnoea on exertion and palpitation of the heart. There was no hysterical tendency in any of the patients.

The author employs mild but continuous counter-irritation over the painful joints, generally iodine or some preparation containing it; while internally he gives dilute nitro-hydrochloric acid with iron, generally the tincture. Very often he employs digitalis with *nux vomica* as cardiac tonics and

sometimes cod-liver oil or arsenic.—*Bristol Med.-Chir. Jour.*, Sept., 1887.

Arnold (E. S. F.) on the Treatment of Rheumatism.—When the late Dr. Robert Nelson, for many years the Mott of Canada, went to California, I succeeded him in his office in New York. During his absence constant inquiries were made of me for his remedy for rheumatism. On his return I asked him what this wonderful remedy was. He smiled, then simply answered, "Colchicum." Seeing that I was incredulous, he then told me that he had once at the Hotel Dieu, in Montreal, experimented with colchicum, trying all the official preparations, sometimes with benefit, but in the main finding all unreliable and often totally worthless. He ultimately tried a strong alcoholic tincture prepared from fresh seed. He found that the shell of the seed contained a volatile oil, that when water was added to the tincture it became opalescent, like tincture of myrrh, and by its use he obtained extraordinary effects. He prepared it by adding to one ounce of the seed half a pint of highest proof alcohol. After standing a fortnight and shaking once or twice daily it was fit for use. Add five drachms of this tincture to half a pint of water, or, rather, enough to make a half-pint, and of this the full dose is half an ounce. "Now," said he, "if you have a case of acute or subacute rheumatism give this every four hours, night and day, avoiding acids and giving a light diet until the toxic effects of the colchicum are induced, viz., nausea or even vomiting, with active purging, which occurs generally by the time the sixteen doses are taken, and the rheumatism will disappear like a flash. Up to this period there will be apparently no relief." He cautioned, if I would secure the beneficial effects, always to prepare it myself.

In cases of acute and subacute rheumatism I have never found its equal, also in rheumatic gout. In simple local or chronic rheumatism, I do not expect any thing from it.—*Coll. and Clin. Record*, Sept. 1, 1887.

Osler (W.) on the Cardiac Relations of Chorea.—A study of the author's cases justifies the following conclusions:

1. That in a considerable proportion of cases of chorea—much larger than has hitherto been supposed—the complicating endocarditis lays the foundation of organic heart disease.

2. In a majority of the cases the cardiac affection is independent of rheumatism, and cannot be regarded as in any way associated with it; unless, indeed, we hold with Bouillaud, that in the disease "*chez les jeunes sujets le cœur se comporte comme une articulation.*"

3. As the presence of an apex systolic murmur in chorea is usually an indication of the existence of mitral valvulitis, as much care should be exercised in this condition as in the acute endocarditis of rheumatism. Rest, avoidance of excitement, and care in convalescence, may do much to limit a valvulitis, and obviate, possibly, the liability to those chronic nutritional changes in the valves wherein lies, after all, the main danger.—*Am. Jour. Med. Sci.*, Oct., 1887.

Schlemmer (G.) on Threatened Abortion Probably Due to the Reflex-Irritation of a Lumbricoid Worm.—A young woman had advanced to the sixth month of her first pregnancy with no untoward symptoms. At that time she was seized with an acute pneumonia of the base of the left lung. On the fifth day of the pneumonia the patient complained greatly of abdominal cramps, and an examination revealed a dilated os uteri and other indications of threatened abortion. Much nausea was present, and the matters vomited were bile-stained and bloody. An emetic dose of ipecac brought about the ejection from the stomach of a large, living lumbricoid worm, after which all the symptoms of threatened abortion abated.—*Gaz. Hebdomadaire*, Aug. 5, 1887.

Macartney (J.) on Enteric Fever as Seen in India and in Other Tropical and Sub-Tropical Countries.—Since the comparatively recent general recognition of enteric fever in India, and in other countries where malaria is prevalent, a constant disposition has been evinced on the part of individual observers to describe it as something different from that fever as it occurs in Europe. The author points out the fact that, in India, enteric fever occurs in a widespread manner, without connection between individual cases as in Europe.

There are also many febrile disturbances, lasting a week or ten days, having typhoid characteristics. Constipation or alternating constipation and diarrhoea is often seen. The rose-colored spots are often faint and few and the intestinal lesions slight. In a large proportion of cases, relapses or a sec-

ondary fever occurs. The temperature curve is atypical. The fever is sudden in its accession, irregular in its course, and liable to change its character before its termination. A period of incubation of more than two or three days is seldom seen. The explanation the author suggests for this peculiarity of foreign fever "is that the *materies morbi* of enteric fever exists in India in many gradations of intensity, and that the severity of any given case is in proportion rather to the strength and maturity of the poison entering the system than to the quantity.

Whilst in cold countries the poison appears to come to maturity more slowly, but more certainly capable of producing the disease in a virulent form with all its characteristic symptoms, in India this does not appear to hold good.

The explanation I would offer is that the source of enteric-fever poison, faecally contaminated water, undergoes the process of zymosis, or fermentation, more rapidly under the favoring influence of open drains, heat, and moisture in India; but that the microbe outruns its own growth as it were, and less often, in proportion to its immature production in India, attains the full degree of elaboration which a longer period, under less forcing influences, enables it to arrive at in the dark, cold, underground sewers of Europe.—*Br. Med. Jour.*, Oct. 8, 1887.

Lawrence (W. B.) on the Treatment of Malarial Fever in the Infant and Young Child.—Suppose the case of an infant, for example, say four months of age, with pernicious intermittent fever. In the cold stage, my experience is that they remain for a shorter time than older children or adults, and that we can more quickly, and with less work, bring about reaction. In the 4-month infant this is generally done by applying heat to the surface or wrapping the child in a blanket. But we may have much trouble with the infant in the hot or fever stage, and more especially if it goes into convulsions. Should the fever go very high, aconite, nitre, paregoric, and bromide of potassium in water, dose according to age; the sick stomach, which we frequently find to be very annoying, is oftenest relieved by bromide of potassium or a creasote mixture. If convulsions come on, put the little fellow in a warm bath or wrap in a warm wet sheet or cloth of a proper kind, move the bowels as soon as possible by enema,

and if you can't give the antispasmodic by the mouth, administer it by the rectum,—such as hydrate of chloral or bromide of potassium. As soon as the sick stomach subsides and the temperature is on the decrease, as a general rule, I think it quite necessary to give an active purgative. Not always, but quite often, order mercury in the form of calomel, and in these extremely pernicious attacks, I have not been able to find any thing to take its place. Quinine must then be given. If the stomach can retain it, it is best disguised by liquorice. If the stomach is irritable it should be given by enema or by inunction, mixed with pure lard.

Concerning the treatment in this form of fever in the young child, 5 or 6 years of age. These cases we can manage with more satisfaction to ourselves than we can in the infant, for the reason that it will allow more to be done for its relief. In the cold stage we will find often more urgent treatment required than in the little fellows. I should, in the first place, see that the heart's action is kept normal, if possible, with stimulants; they may be alcoholic—brandy or whisky will suffice; but if they fail I should try ether, and with it ammonia, by inhalation and mouth. I have also very frequently given nitrite of amyl by inhalation; dose ℥ ij-v , in a handkerchief is a very convenient mode of administration, and I have found this to be a very valuable remedy. In fact, I think it one of the best stimulants in this stage of the disease. In some cases, at this age, I have given morphine hypodermically; and especially in cases suffering with sick stomach and restlessness, I find that it affords great relief, brings about quiet, and aids good circulation very much, and in many cases is the only thing that will give relief. I have given chloroform in from eight to ten minims, but with little good, if any. While administering the above remedies, or some others, I order mustard in the form of plasters to the ankles and wrists and, at the same time, friction with flannel cloths.

In the hot stage *veratrum viride* seems the most efficient and safe remedy. As a general thing a calomel purge should be given, followed by gr. xx of quinine in 12–15 hours.

In the treatment of remittent fever, so soon as you are sure you have this form of fever to treat, there is that old remedy which is required in all cases, namely,

cinchona, or its equivalent, quinia. In sthenic cases I should employ a light febrifuge, and as soon as the fever gives away give a proper amount of quinine, for restlessness; in insomnia, give bromide of potash and comp. pulv. ipecac; open the bowels freely, apply frequently cold cloths to the head, and order a warm mustard foot-bath. These remedies often do much good.

We may be forced to do more than this if the fever takes on a pernicious form. The patient may require chloral hydrate or morphine to quiet him, or a mild, mercurial purgative, frequently combined with santonine, followed with oil. The fever gives away in a number of instances within 10 or 12 hours. But frequently in a child of from 5 to 8 years of age this fever will continue in spite of all our treatment, for 10 or 15 days, and maybe longer. After active treatment for 3 or 4 days, and the symptoms point to such a continuation, we begin a treatment similar to that of typhoid fever; that is, use tonic doses of quinine and one of the acids. A mild febrifuge, if necessary, keeps the bowels regular, and light stimulants after fever has continued some days. Order iron to be given for a short time after the fever has given away.—*Four. Amer. Med. Ass'n*, Oct. 15, 1887.

Seay (R. W.) on Aids in the Prevention of Fevers.—Among the causes of fever the author says there are:

1. Arterial contraction.
2. Accelerated action of heart.
3. Increased tissue metamorphosis or oxidation.
4. Probably a nervous influence causing an inhibitory influence on the usual changes in transformation.

If we can give remedies which will prevent the three first known causes mentioned and the last theoretical cause, we can lessen or entirely prevent the occurrence of fever, in many cases. We all use these remedies in the pyrexia, and we can advantageously use them in the preventive treatment. We have such remedies in *veratrum viride*, *aconite*, and similar remedies. *Veratrum viride* acts upon the cardiac ganglia and the muscular substance of the heart, as is proved by paralyzing the pneumogastric with atropia, and it still affects these parts. *Aconite*, we are told, acts in the same way. I do not mean, in using these remedies, to prohibit the use of quinine, but that their proper use is, as sug-

gested, as *aids in the prevention of fevers*. Use, for instance, for an adult not very weak, this prescription :

R Tr. veratri viridi (Norwood's), ℥.xxxij.
Tr. aconitii ℥.xxxij.
Spits. ætheris nitrosi 3 iv.
Aque q. s. ad. 3 j. M.

S.—Give, in a half-wineglass of water, a teaspoonful every 3 hours, beginning 9 hours before the expected return of fever, and discontinue after fever time has passed.

I desire to impress upon you that I wish to recommend medicine which will prevent the four causes which I have summed up as producing fever, rather than recommend any particular medicines, for we may have our own preference for several remedies, either of which may produce the same effect. One may prefer, for instance, veratrum viride to either aconite or gelsemium, while another may prefer to use aconite in preference to any of the other cardiac sedatives.—*Four. Amer. Med. Ass'n*, Oct. 1, 1887.

Wharton (H. R.) on Seven Cases of Gangrenous Stomatitis.—The author narrates in detail seven cases of gangrenous stomatitis in children following measles; he summarizes his observations as follows :

"If one examines carefully the mouth of a patient suffering from gangrenous stomatitis, he will see upon the gums or upon the mucous membrane of the swollen cheek an ulcerated surface covered with a brownish or greenish or dirty gray-colored slough surrounded by œdematous mucous membrane. If the disease is well advanced, the bone of the jaw and soft palate may be seen blackened and dead, and the discolored teeth are found to be loosely held in their sockets, and may be shed or can be easily drawn. There is also a profuse discharge of fetid saliva, and the sub-maxillary lymphatic glands are generally enlarged.

"In severe cases the gangrenous process extends rapidly to the cheek where a black slough appears, and this may drop out, leaving the cavity of the mouth exposed, causing the patient to present a most horrible deformity.

"The seat of perforation of the cheek is generally continuous with the most extensive seat of disease in the jaw; the cheek corresponding to either the upper or the lower jaw may be involved. I remember a case which was under my care at the Children's Hospital a few years ago, in which a portion of the lower lip and chin

was destroyed by a slough; in this patient recovery took place, and the deformity was very well relieved by a plastic operation. If patients survive after extensive destruction of the cheek, it is often impossible to obtain sufficient flaps to cover the gap in the cheek, and there is often so much cicatricial contraction that the motion of the lower jaw is impaired, or it may be completely locked; in either of these events the patient presents a most miserable condition.

"During the time that these local conditions exist in the mouth the patient has a more or less elevated temperature, but generally rests well and rarely refuses nourishment; it is often remarkable to see these patients continue to take nourishment with apparent relish almost up to the time of the fatal termination.

"The principal complications occurring in the course of the disease are diarrhœa, broncho-pneumonia, and hemorrhage. The former of these is, I think, one of the most constant complications, and is probably due to the ingestion of gangrenous or septic matter with the food, and the exhaustion following it is a very frequent cause of death. In the case in which a post-mortem examination was made, the causation of the diarrhœa is explained by the condition of the mucous membrane of the large intestine.

"Broncho-pneumonia is another complication of comparative frequency, and is probably produced by the aspiration of gangrenous fluids and gases into the air passage.

"Hemorrhage occurring at the time of the separation of the sloughs may be a serious complication, and in one case the exhaustion following this accident was an important factor in the fatal issue.

"In the treatment of this disease, it is most important that the patient be given a nutritious and early assimilated diet together with stimulants; and at the same time the administration of quinine and iron with the mineral acids is often followed by the best results. The administration of opium has been recommended in this affection by reason of the influence it seems to exert in controlling the spread of gangrenous diseases; but with its use in this disease I have had no personal experience. The local treatment which I have found most satisfactory is the removal of the gangrenous tissue as far as possible by scraping, and the

thorough application of nitric acid to the affected parts. The application of the actual cautery to the diseased surfaces (and the most convenient form for its use is by means of Pacquelin's cautery) has also been highly recommended, and it has the advantage over the use of nitric acid that its action is more readily controlled.

"The mouth should be kept constantly washed with some form of disinfectant solution, and I have used with advantage a solution of chlorate of potassium with glycerine and tr. myrrh, or an infusion of sumac with chlorate of potassium.

"In cases which terminate favorably, the sloughs separate and the ulcerated surfaces are covered with healthy granulations; the necrosed bone becomes loose, and is either thrown off or can be easily removed; and with the improvement in the local condition there is a corresponding change in the patient's constitutional state."—*Med. and Surg. Reporter*, Sept. 17, 1887.

Skinner (W. W.) on the Treatment of Sea-Sickness.—The medicinal substances employed are atropine, strychnine, and caffeine; the two former are administered simultaneously, the latter alone. Sea-sickness may be cured either by atropine associated with strychnine or by caffeine held in concentrated solution by salicylate or benzoate of sodium. These substances are all administered hypodermically. This mode of administration was chosen for the following reasons: the frequent vomiting in naupathia, by which the agents employed would be lost; the difficulty of their absorption from the stomach in this affection; and also the retaining and destructive action of the liver upon these alkaloids when absorbed from the gastro-intestinal tract.

The dose of atropine and strychnine for adults is 1 milligramme of each. It would, perhaps, be better to give a little less of atropine and the double or triple of strychnine. The following, however, is the formula I have employed up to the present time: Atropinæ sulph., strychninæ sulph., $\overline{aa}$ 0.04 gramme (gr. $\frac{3}{4}$); aq. menthæ, 40 grammes, (3 x). One gramme of this solution contains 1 milligramme of each of the alkaloid salts. In warm climates the solution must be frequently renewed. Although these substances have been employed a great many times for sea-sickness during the last eighteen months, no injurious effect therefrom has been observed. If after two hours

the patient is not cured, a second injection of 1 gramme of the mixture may be given, but it would be imprudent to repeat this dose of atropine too frequently.

The following is the formula employed in administering caffeine to adults: Caffeine, 4 grammes (3 i.); sodii salicyl., 3 grammes (gr. xlv.); aq. destill., q. s. ad 10 (3 iiss) cubic centimetres. Dissolve by gentle heating. Each cubic centimetre contains 0.40 of a gramme of caffeine. A single hypodermic injection of 0.30 of a gramme of caffeine completely cured in seven hours a patient who had been suffering intensely from sea-sickness during three days. Another patient was cured in five hours.—*Br. Med. Jour.*, Oct. 8, 1887.

DISEASES OF WOMEN.

Heudoupe (F.) on a Calcareous Tumor of the Breast.—A woman of 35 consulted the doctor for what she called an abscess of the breast. There was a large, irregular ulceration on the upper part of the left breast, from which creamy pus freely escaped. The cavity of the abscess was three quarters filled by a hard tumor which gave a sensation of porous stone to the probe.

The part was benumbed with a spray of ether and the calcareous mass was removed. It was about the size of an egg.

The antecedent history of the woman was as follows:

At the age of 15 she hurt the left breast in a fall. A painless tumor the size of a nut developed in the breast.

The woman married and had two children, which she nursed. She noticed the secretion of milk was always more profuse from the diseased breast. Four years before the calcification was removed another traumatism to the breast occurred, and an abscess developed which was opened, and a fistulous tract was left which persisted.—*Gaz. des Hôp.*, Aug. 25, 1887.

Mettler (L. H.) on the Menopause and Some of Its Disorders.—In the treatment of climacteric neuroses the hygienic surroundings need particular attention. Fresh air, nourishing food, and cheerful company are far more efficacious in warding off distressing symptoms than drugs are in removing them when they have once made their appearance. The nervous system particularly must be kept

quiet, away from all disturbing influences, such as worry, excessive emotion, or mental strain. This alone will do much in assuring the patient's comfort while passing through this trying period. The prolonged strain made upon the blood during the menstrual epoch has, somehow, so weakened its nutritive powers, that all the organs of the body feel the lack of its supporting influence in carrying out their proper functions. Without doubt this state of the blood, added to the ovarian excitation, explains in quite a satisfactory way the neurasthenia during the period of change. Hence there should always be a judicious use of tonics, tonics that go to increase the corpuscular richness of the blood. Of such iron is admittedly the best. To iron may be added certain other substances, such as the fibrine of dark meat, broth, raw flesh, when properly guaranteed, maltine, pepsin, and proteine. With the iron it is well to combine some one of the special nerve tonics, such as arsenic, strychnia, quinine, etc. These have the effect of toning up the nervous system, as well as stimulating the blood-making organs to greater activity. I have had excellent tonic effects from a pill which I frequently use containing one fortieth of a grain each of arsenious acid and strychnine, one grain of quinine, and two grains of sulphate of iron. In this tonic course of treatment a weak digestion must never be lost sight of.

Some form of pepsin, or, what I like very much, the lactopeptine powder, may be used with signal advantage after meals. The skin, generative organs, and muscular system must all be kept in the best hygienic condition; cleanliness and a proper amount of exercise are imperative. When these general indications of treatment shall have been faithfully carried out there will be little need of special remedies. When they do become necessary, however, our employment of them should be as judicious as is consistent with our ignorance of the causes of the symptoms indicating their use, and just here will the physician have an exquisite opportunity to test his diagnostic and therapeutic skill. The different causes of headache, of restlessness, of the deteriorated blood condition, of the general constitutional debility, with its attendant flushings, chills, and night-sweats, of the dyspepsia, leucorrhœa, and diarrhœa, and of the hemorrhages, will all call for differ-

ent forms of medication.—*Medical Register*, Oct. 1, 1887.

On Uniformity in Obstetrical Nomenclature.—The following definitions and designations are worthy of general adoption by obstetric teachers and authors:

I. PELVIC BRIM DIAMETERS.—1. Antero-posterior: (1) Between the middle of the sacral promontory and the point in the upper border of the symphysis pubis crossed by the *linea terminalis* = *Diameter Conjugata vera*, Cv. (2) Between the middle of the promontory of the sacrum and the lower border of the symphysis pubis = *Diameter Conjugata diagonalis*, Cd.

2. Transverse: Between the most distant points in the right and left ileo-pectineal lines = *Diameter Transversa*, T.

3. First Oblique: Between right sacroiliac synchondrosis and left pectineal eminence = *Diameter Diagonalis Dextra*, D. D.

4. Second Oblique: Between left sacroiliac synchondrosis and right pectineal eminence = *Diameter Diagonalis, Læva*, D. L.

II. FŒTAL HEAD DIAMETERS.—1. From the tip of the occipital bone to the centre of the lower margin of the chin = *Diameter Occipito-Mentalis*, O. M.

2. From the occipital protuberance to the root of the nose = *Diameter Occipito-Frontalis*, O. F.

3. From the point of union of the neck and occiput to the centre of the anterior fontanelle = *Diameter sub-Occipito-Bregmatica*, s. O. B.

4. Between the two parietal protuberances = *Diameter Bi-Parietalis*, Bi-P.

5. Between the two lower extremities of the coronal suture = *Diameter Bi-temporalis*, Bi-T.

III. PRESENTATION OF THE FŒTUS.—

The *presenting part* is the part which is touched by the finger through the vaginal canal, or which, during labor, is bounded by the girdle of resistance.

The *occiput* is the portion of the head lying behind the posterior fontanelle.

The *sinciput* is the portion of the head lying in front of the *bregma* (or anterior fontanelle).

The *vertex* is the portion of the head lying between the fontanelles and extending laterally to the parietal protuberances.

Three groups of presentations are to be recognized, two of which have the long axis of the fœtus in correspondence with the long axis of the uterus, while in the

third the long axis of the fœtus is more oblique or transverse to the uterine axis.

1. Longitudinal: (1) Cephalic, including—vertex and its modifications; face and its modifications; (2) pelvic, including—breech; feet.

2. Transverse or trunk, including shoulder, or arm, and other rarer presentations.

IV. POSITIONS OF THE FŒTUS.—The positions of the fœtus are best named topographically, according as the denominator looks—first, to the left or the right side, and second, anteriorly or posteriorly. When initial letters are employed it is desirable to use the initials of the Latin words.

In the case of Vertex positions we have:

Left Occipito-Anterior = *Occipito-Læva-Anterior*, O. L. A.

Left Occipito-Posterior = *Occipito-Læva-Posterior*, O. L. P.

Right Occipito-Posterior = *Occipito-Dextra-Posterior*, O. D. P.

Right Occipito-Anterior = *Occipito-Dextra-Anterior*, O. D. A.

The Face positions are:

Right Mento-Posterior = *Mento-Dextra-Posterior*, M. D. P.

Right Mento-Anterior = *Mento-Dextra-Anterior*, M. D. A.

Left Mento-Anterior = *Mento-Læva-Anterior*, M. L. A.

Left Mento-Posterior = *Mento-Læva-Posterior*, M. L. P.

The Pelvic positions are:

Left Sacro-Anterior = *Sacro-Læva-Anterior*, S. L. A.

Left Sacro-Posterior = *Sacro-Læva-Posterior*, S. L. P.

Right Sacro-Posterior = *Sacro-Dextra-Posterior*, S. D. P.

Right Sacro-Anterior = *Sacro-Dextra-Anterior*, S. D. A.

The Shoulder presentations are (left and right side of the mother):

Left Scapula-Anterior = *Scapula-Læva-Anterior*, Sc. L. A.

Left Scapula-Posterior = *Scapula-Læva-Posterior*, Sc. L. P.

Right Scapula-Posterior = *Scapula-Dextra-Posterior*, Sc. D. P.

Right Scapula-Anterior = *Scapula-Dextra-Anterior*, Sc. D. A.

V. THE STAGES OF LABOR.—Labor is divisible into three stages: (1) First stage—from the commencement of regular pains till complete dilatation of the os externum = *Stage of Effacement and Dilatation*. (2) Second stage—from dilatation of os exter-

num till complete extrusion of child = *Stage of Expulsion*. (3) Third stage—from expulsion of child to complete extrusion of placenta and membranes = *Stage of the After-birth*.

VI. THE FACTORS OF LABOR ARE—(1) The Powers. (2) The Passages. (3) The Passengers.

(Signed) DE LASKIE MILLER, M.D.,
President of the Section.

A. F. A. KING, M.D.

WILLIAM T. LUSK, M.D.

A. R. SIMPSON, M.D.

—*N. Y. Med. Record*, Sept. 17, 1887.

Davis (H.) on an Unusual Relaxation of the Female Urethra.—The subject was a married woman, aged 42, who had never been pregnant. She was suffering from retroflexion of the uterus, and I had introduced a ring pessary into the vagina.

At a subsequent visit I was much embarrassed by the following appearances. Unusual smoothness of vagina, which projected very much anteriorly, and contained no pessary; uterus entirely retroverted, the os pointing upwards and beyond my reach; an obscure movable tumor, which I had not previously noticed, lying along the sacrum.

I determined upon trying a still larger ring, and only then discovered that my obscure tumor was the original instrument occupying its proper situation. I had been exploring the cavity of the bladder. The urethra was sufficiently dilated to admit two fingers quite easily. The posterior lip of the orifice was enormously hypertrophied, and stretched like a valve across the vagina.—*Br. Med. Jour.*, Sept. 17, 1887.

Simson (F. T.) on Successful Treatment of Pruritus Vulvæ.—Mrs. X—, an elderly lady, wife of a wealthy merchant, consulted me some time back complaining of great irritation of the vulva and perineum. She was suffering from diabetes, but although under treatment the specific gravity of her urine decreased from 1049 to 1026, yet the pruritus increased in severity. In spite of all that could be suggested by myself and many of the best London consultants, life became almost unbearable. Directly she became warm in bed the irritation would commence. She would scratch herself "almost to pieces," and would frequently leave her bed half-a-dozen times during the night to sit in a bath of cold water. She tried alkaline baths, hydro-

cyanic acid, black wash, chloroform liniment, etc., without avail. On July 28th she came up from the country to see me, although she felt it might be in vain. I then gave her the following ointment:—Cocain., 15 gr.; aquæ dest., q.s.; lanolin., $\frac{1}{2}$ oz.; to be used every night, and lotio hydrargyri nigra to be applied in the morning after bathing. Since she used this ointment the irritation gradually decreased, until it entirely left her, and long and healthy sleep returning has made life again worth the living.—*Lancet*, Sept. 10, 1887.

Miller (F. C.) on a Polypus Complicating Pregnancy.—On the 21st of last December I was called to attend Mrs. W., in confinement. She had a normal labor and was soon delivered of large male child. The uterus contracted firmly, but I failed to deliver the placenta until, after considerable trouble, I succeeded in dilating the uterus sufficiently to admit my hand. I then succeeded in separating the placenta from the walls of the uterus, when both my hand and placenta were expelled by contraction of the uterus. I examined carefully and satisfied myself that I had delivered the whole of the placenta. I was informed by the husband that she had been delivered of a child four years before, and that she was troubled for months with spells of flooding. She got along very finely until about the 10th day, when, on trying to sit up for a little while, she was taken with a pain resembling a labor pain, and soon began to flow to an alarming extent. I was sent for, and soon stopped the flow with ergot. After this I was sent for almost daily, she saying that was just the way she was before. I finally placed her on five-drop doses of the oil of erigeron every two hours. She had been on this treatment for about six days, when I was sent for to see "what had passed her." I found a polypoid tumor about the size of a small pullet's egg, with a pedicle about one half inch long. The tumor was firm and solid, the neck being almost transparent, somewhat resembling tendon.

She made a rapid recovery, and has enjoyed perfect health ever since.—*Med. Age*, Sept. 10, 1887.

Johnstone (A. W.) on the Infantile Uterus.—The uterus is not only an entirely independent organ, but it is made up of two parts, whose functions are entirely separate, and arrest of growth may occur in either or both.

From its exposed position, the growth of the cervix is much oftener interfered with than that of the body.

Congenital flexion is largely due to this arrest.

The arrested growth of the body nearly always means an interference with the proper development of the endometrium.

This immaturity of the endometrium prevents its progress to the myeloid state necessary to the formation of the placenta, which means permanent sterility.

This interference is most probably due to some damage to the plevic sympathetic.

Where there is marked diminution in the body, the stretching of the neck is apt to result in little if any good.

When life has become a burden that is clearly due to an arrest of development, the menopause should be hastened, but not until we are sure nothing else can relieve.—*Am. Jour. Obstetrics*, etc., Oct., 1887.

Palmer (C. D.) on the Therapeutic Value of Some Medicines in the Treatment of Hemorrhagic Conditions of the Uterus.—Referring to the fact that gynecology has assumed a decidedly surgical tendency, the author says that too little attention has been paid to the less brilliant medicinal treatment. Uterine hemorrhage can often be treated advantageously by means of drugs, such as ergot, digitalis, cannabis Indica, bromide of potassium, arsenic, and gallic acid. Ergot is especially useful in cases of chronic hyperæmia and subinvolution of the uterus attended by menorrhagia, where the organ is soft and relaxed, and of interstitial and submucous fibroids. Hemorrhages due to fungus endometritis, ovarian and parametric inflammation are not favorably affected. Digitalis is useful in uterine hemorrhage due to cardiac disease.

Cannabis Indica is an uncertain drug, acting rather upon the nervous system. Bromide of potassium is a sedative in ovarian irritation and congestion, and thus is useful in certain forms of menorrhagia, as well as in the treatment of hemorrhage from subacute and chronic pelvic peritonitis.

Arsenic acts by improving the general condition, and hence is of value in the menorrhagia of young women and at the climacteric, also in malarial conditions. He gave Fowler's solution in three minim doses. Active cathartics often exercise a favorable effect in checking uterine hemor-

rhage, especially if there is evidence of obstruction to the circulation from habitual constipation. In general, the administration of iron during the intermenstrual period is not advisable, unless the patient is markedly anæmic.

Hydrastis Canadensis has been highly recommended as a hæmostatic in uterine hemorrhage from any cause. Garrigues has obtained good results with *gossypium herbaceum*, especially in cases of fibroid tumor. Hamamelis is inferior to ergot for the relief of sudden hemorrhage, but is useful in the treatment of long-continued flux, where the hemorrhage being of a passive character, the uterus is soft and flabby.—*Med. News*, Sept. 24, 1887.

Jackson (A. R.) on the Intra-Uterine Stem in the Treatment of Flexures.—The object of the paper was to present the results that he had observed to follow certain plans of treatment when applied to selected cases, and to explain the details of the method employed.

The single symptom which he requires for the treatment of flexion is dysmenorrhœa. The essential principle in the treatment consists in its slow, gradual conduct. The uterus must be coaxed and not forced into proper shape. He never uses the stem in any case of flexion in which the deformity is not the cause of the dysmenorrhœa, nor until the tolerance of the uterus has been ascertained by previous systematic introduction of the bougie, nor when there is the least evidence of peri-uterine inflammation.—*N. Y. Med. Record*, Sept. 24, 1887.

Martin (A.) on Juniper Catgut: its Use in Gynecological Operations.—The author's experience allows him to recognize in the continuous suture with catgut a great advance in the technique of gynecological operations. This remark applies more particularly to plastic operations on the perineum and vagina, and, to some extent, to operations on the cervix. In the application of catgut to intra-abdominal operations, some other factors likewise enter into the consideration; but, at all events, even for these latter this suture material possesses advantages which must not be overlooked.

The catgut he employs is known by the trade-mark "Wiesener," furnished in Germany by Hartmann, of Heidenheim, in two thicknesses, Nos. 2 and 3. Of this, a pretty large quantity at a time is wound on

glass plates and immersed in a one-tenth-per-cent. solution of corrosive sublimate, for six hours. The entire quantity is then taken out, dried with a clean towel, and placed in a mixture of two parts of alcohol and one part of oil of juniper, contained in large glass vessels with ground glass stoppers, and is ready for use from the sixth day on. When required, the necessary quantity is taken out and kept ready, during the operation, in a small saucer filled with a preservative solution. Prepared in this way, the material possesses great tenacity, so that the threads break very rarely. At the same time they become so flexible that they can be readily tied, provided the wound margins to be united do not offer too great a resistance to coaptation. The catgut threads must always be tied with a triple knot, and a long end allowed to hang free. Of course, in employing the button suture, catgut must be grasped more firmly than silk; hence the skin of the operator's fingers easily cracks, and the fingers get sore more quickly than with silk. But these drawbacks must not be considered so serious as to cause one to dispense with a suture material which does not irritate the stitch-holes, which dissolves after having kept the wound surfaces sufficiently long together, and thus obviates the often inconvenient necessity of removing the sutures.—*Am. Jour. Obstetrics*, etc., October, 1887.

Hunter (J. B.) on Death from a Rare Cause after Laparotomy.—The case was one in which acute dilatation of the stomach occurred after the operation, which was for the removal of both tubes and ovaries for disease of the latter organs of several years' standing, and giving rise to severe dysmenorrhœa.

The peculiarity of the vomiting, which continued at intervals after the operation until death, was that large quantities of fluid were regurgitated without much effort. Tympanites and tenderness were marked; the temperature was 101° F., and it was supposed that the patient had succumbed to a low form of peritonitis.

The autopsy revealed extreme dilatation of the stomach, the organ filling the abdominal cavity, and extending downward to within three inches of the symphysis pubis. The intestines and omentum were crowded into the pelvis. There was no evidence of either old or recent peritonitis. The history of the case excluded previous

gastric disease, and showed that the enlargement had taken place after the operation. There was no obstruction at the pylorus.

The case taught the lesson that every patient who was to be made the subject of laparotomy should be thoroughly examined, since in this way only can the integrity of every organ be assured. Gynæcologists were too apt to confine their attention exclusively to the pelvis, at the risk of overlooking the complications in the thoracic or abdominal viscera.—*Amer. Four. Obstetrics*, etc., Oct., 1887.

Harris (R. P.) on a Tenth Horn-Cesarean Case, with Recovery of the Woman; the subject Being a Pawnee Indian Squaw, and the Animal Inflicting the Injury an American Bison Bull.—Dr. Powell, as a boy, witnessed the goring of the abdomen of a squaw, who was far advanced in pregnancy, by a bison bull, who tore out the foetus and carried it upon his horn, rather than tossed it, a distance of about twenty or more yards. The child was killed by the horn-thrust, but the woman narrowly escaped death. This squaw was about 30 years old, of medium height, not fat, but broad, and strongly built, with all the evidences of perfect health. Such women have been known to recover from injuries of an extremity which, in a civil state of society, would require amputation even to save life. As nearly as Dr. Powell can now recollect through mental association, this calamity happened in the year 1852. The woman made a good recovery under Indian treatment, and was seen alive and well at a later period by *young* Powell.

According to the later experience of Dr. Powell, who has seen abdominal lacerations in men made by the bison, as well as wounds of the same region received under hand-to-hand encounters in battle, treated by the Indians, the process is as follows: A plastic clay is selected, such as may in emergency be dug up from beneath a "buffalo wallow," and made into a stiff mud with water; the wound is held together, while a thick coating is applied; then over this is placed a layer of woody fibre crossed upon it in every direction; then another coat of mud, and so on, until a cake of two inches thick covers the abdomen from flank to flank, the patient being kept upon his back during the treatment. The Pawnees, Utes, Apaches, Sioux, and Comanches make use

of silky fibres obtained from plants for holding the clay together. The sage-brush, so common in Indian regions, furnishes one source of supply; another is a species of evergreen, unknown by name to Dr. Powell, which grows high up in the snowy range of the mountains. In extraordinary years, the fall of snow reaches from twenty to forty feet in depth, covering the trees. The snow partially melts, then freezes, and finally sinks in the warm season, stripping down the bark to the roots, and tearing out the inner bark into long thin strips, which are gathered by the Indians for use in dressing wounds. Choice clays are also stored up and kept for the same purpose.

Thus it will be seen that the dirt treatment in surgery is much older than that of Hewson; as the expression of the placenta has been demonstrated by Engelmann to have long preceded the time of Credé in its use among our Indian tribes.

Of 13 horn-rips in pregnant women, 10 opened the uterus, and 3 did not. Of the 10 women, 6 were saved, and 4 of the 6 matured children; the 3 cases of the second class all recovered, did not miscarry, and bore living children at maturity. Those who claim that the Cesarean operation is one of the most fatal in surgery, should weigh these facts, determine how much of the risk is due to the condition of the subject at the time the knife is reluctantly used, and how much to the operation itself. Germany has demonstrated the latter pretty conclusively within the last five years. It may be claimed that the horn-ripped women were in the best possible physical condition at the time of the casualty. True; but can this outweigh the difference of shock produced by the sudden horn-thrust, and the carefully used knife under anæsthetic unconsciousness, respectively? Test the work of the knife upon the rachitic woman in the commencement of labor, as has been done in Leipzig and Dresden, and note the diminished rate of death under the Säger method. Then compare this with the fatal results under the same method in the United States, when resorted to after physical exhaustion, and we can understand what must be the *sine qua non* if we are to secure future success, as in the exceptional Lusk case at Bellevue Hospital, New York.—*Am. Four. Obstetrics*, etc., Oct., 1887.

DISEASES OF THE SKIN.

Fournier on the Hypodermic Treatment of Syphilis.—This celebrated authority says: "My opinion is that it is not a good treatment. You must treat your patients so as to please or, at least, not to displease them. The injections are painful, they interfere with the patients' avocation, they necessitate frequently repeated visits. Above all, the method is not practicable. In private practice patients will not tolerate it. In hospital practice it is possible, but note the result: patients leave other hospitals where this treatment is employed and flock to the St. Louis, where they know they will not receive it."—Letter to *Four. Cut. and Gen. Urin. Dis.*, Sept., 1887.

Matas (R.) on a Case of a Patient from Whose Subcutaneous Tissue Three Larvæ of a Species of Dermatitis were Removed.—On the morning of June 27th, an Englishman, aged 38, presented himself at my clinic in ward 8, Charity Hospital, stating that he had arrived in this city, one week before, from an extensive trip to Spanish Honduras, where, on or about the 11th of this month (June), he had been stung, while bathing, by a peculiar fly, which was well known in that country, as it was a veritable nuisance, if not a scourge, because it attacked man and beast alike—the white foreigners especially,—and deposited its ova in the sting, wherein the "worms" (larvæ) developed until they attained considerable dimensions—half to three-quarters of an inch in length, according to the patient's statement. He further stated that he remembered the moment when the fly stung him, for he heard it "buzz," and "sting" him in three distinct places on his body, where he was sure the "worms" were now growing, "though they must be still quite young and small, on account of the comparatively short time that they had been in the flesh"—*i. e.*, sixteen days since ova had been deposited.

We then examined the patient, who, after undressing, showed us three red, hard, furuncular swellings, situated—one on the right side of the intergluteal furrow, about two or three inches from tip of coccyx, and two other similar, though smaller, elevations on the left side of the same furrow and closely adjoining one another. The first, which was the most prominent, was elevated at its highest por-

tion about one-quarter of an inch from the level of the surrounding skin, and presented a circular area of inflammatory hardness which measured about one and one-quarter inch in diameter. Upon careful and minute inspection the largest furunculoid mass was found to present in its most elevated and central portion a minute orifice, which might admit the point of a coarse bristle. The other two swellings presented also one central point each, where a little puriform crust had become fixed, indicating the original seat of puncture and entrance to the larval sinus.

We proceeded to the extraction of the parasites—a procedure which the patient urgently requested. Guided by the orifice in the elevation I cut with the point of a bistoury into the very centre of the swelling, but discovered, however, that by simply cutting *vertically* I had not incised the cavity wherein the larvæ lay concealed, and was obliged to again incise obliquely and to the right in order to expose the parasitic burrow. This oblique direction of the larval sinus I found to be constant in each of the three "stings." I found that the larvæ were lodged immediately under the derma proper, so that in getting at them, in order to expose them thoroughly, I had to cut completely through the skin, which, in the gluteal region, is pretty thick. It was discovered also that a simple incision was insufficient to remove the larvæ, and that digital expression, and this very forcibly applied, was necessary in order to induce them to relinquish their stronghold. In fact, the two last larvæ were removed more by this means than by incision, the orifice of the sinus having been simply incised in order to enlarge the orifice of exit, and the parts expressed by pinching them in a fold of skin. The patient stated that in Honduras the natives usually rid themselves of these unpleasant guests by applying hot tobacco ashes to the parts and following this up by digital expression. This is a rather general treatment for parasitic dermal affections in Latin-American countries, where tobacco is always on hand. In our patient's case we cauterized the cavity or sinus left by the evacuation of the larvæ with pure carbolic acid, for fear that the septic products of larval nutrition might tend to create inflammatory mischief.

Since this case has come under my observation I have been informed that similar instances of larval deposits in the skin

have not been rare in the hospital, at least since the Panama Canal and other enterprises have increased the traffic between this port and the Central American republics.

The three specimens are mounted in a glycerine cell, and are smaller than they appeared in life. The largest of these measures about four or five mm. in its long diameter and is about one and one-half mm. in breadth. To the naked eye they present an elongated pyriform or clavate appearance, the broad, thick, and rounded portion corresponding to the head and trunk, which were the parts farthest from the surface of the skin; the long, tapering or caudal extremity pointed upwards, so that in squeezing the larva out of its lodgment the tail end appeared first. As the caudal extremity presented itself a dark red dot was visible at the very extremity. This corresponded to the dark anal extremity containing the stigmata for respiratory purposes, and is characteristic of, though not peculiar to, the *dermatobia* larvæ.

This is the normal position of these parasites in general, for the respiratory apparatus which is attached to the caudal portion, close to the anus, is placed near the opening originally made by the sting of the parent fly, in order that they may be as close as possible to the atmosphere. When the larvæ were extracted they wriggled quite actively in their vermicular movements, and continued to move until they were embalmed in the cell five or six hours after their extraction.

On microscopical examination of the most perfect specimen, a remarkable appearance is presented. The major portion of the parasite is seen to consist of an elongated, pyriform, tuberoso, or exaggerated clavate body, apparently concave on the ventral aspect and convex dorsally, terminating in a long, tapering, glabrous, elongated-pyramidal extremity. The broader and truncated part of the larva is opaque, and none of the contained organs can be distinguished. Corresponding to the three dark zones distinctly outlined with the naked eye are seen three *double* rows of black hooklets or spines, which are distinctly shaped, when examined carefully, like the thorns of a rose stem. They are lamelliform, sharply pointed at the ends, and are curved and directed (the majority) towards the caudal extremity, so that, if embedded in the tissues lining the larval

sinus, they would offer a resistance to caudal traction in direct ratio to the force employed. This arrangement is manifestly calculated to assist the larva in retaining its position in the subcutaneous tissues, and especially in preventing any involuntary migrations from regions subjected to great muscular disturbance. They may also assist in burrowing, though advance or head movements do not appear to be habitual with these larvæ, as they, in common with most ectodermic parasites, are not anaerobic (to use a Pasteurian phrase), but require the presence of atmospheric oxygen for their maintenance.

In addition to the three rows of hooklets a large number of small punctiform and blackish tuberosities are seen dotted in a somewhat concentric manner above the upper row, on the two upper segments and the vicinity of the oral point.

From the preceding description and the facts furnished by the patient as to the circumstances by which he was made the host of these unpleasant guests, it is quite plain that these parasites—"beef or screw worms of Honduras," as my patient said they were called in that country by the English-speaking residents—are the larvæ of the species of gadfly (*æstrus*), which may be peculiar to Central America, but which, from the imperfect entomological analysis of the specimens removed from my case, I would regard as the offspring of the *æstridæ* or gadflies, which entomologists have already classed in a special order known as the *Dermatobia*.

There are three species of *æstridæ* which especially attack the subcutaneous tissue of man, with the view of depositing their larvæ therein: 1st, the *hypoderma bovis*, which in Europe preferably attacks cattle and rarely man; 2d, the *cuterebra* of Clark (entirely an American order), which attacks beast and man; 3d, the *dermatobia* of Brauer, which were believed to be especially attached to man, but erroneously so, as will be shown further on.

The *Hypoderma bovis* is an *æstrus* which closely resembles the drone bee. It possesses a proboscis, but has no distinct palpi; the third segment of the antennæ is transverse; its mouth has the shape of a Y; its third segment is covered with black pubescence; the wings are wide apart, of a brownish color. The female has a longer abdomen than the male. The length of the perfect insect is about eleven to thirteen

mm.—*New Orleans Med. and Surg. Jour.*, Sept., 1887.

Jackson (G. T.) on Resorcin.—The author thinks that resorcin is an irritating substance for use in eczema, though at times it may prove very efficient in chronic cases where active stimulation is indicated. It exerts a powerful absorptive effect on new cell infiltrations. It is a useful addition to our list of remedies for the treatment of epitheliomatous lesions where surgical procedures are contra-indicated from any cause.—

Four. Cut. and Gen.-Urin. Dis., July, 1887.

Thin (G.) on the Pathology and Treatment of Ringworm.—The author's method of treatment is as follows: In a very young child, say a child under three years of age, after the head has been prepared for treatment he usually begins by applying simple *sulphur ointment* in the proportion of 1 drachm to an ounce. If this is well borne, as is usually the case, and the disease does not yield, he increases the strength of the sulphur. With this treatment, or without it, tincture of iodine may be used more or less successfully according to the age of the child. In a very young child the hairs are not planted deeply in the scalp, and milder treatment which is successful in ringworm of the body may not improbably succeed. In the case of a very young child, sulphur cautiously and continuously applied will usually lead to a cure. If it fails after sufficient trial, the remedies used for older children must be cautiously applied over a surface not too large.

For children of four or five years of age, in addition to sulphur ointment, he is in the habit of prescribing a solution of *carbolic acid* in *glycerine*, beginning with a weak strength (1 in 8). If the child has a delicate skin, he combines the carbolic-glycerine treatment with sulphur ointment (1 or 2 drams to the ounce), directing that the glycerine be well rubbed into the affected parts twice daily, and half an hour afterwards that the ointment be rubbed in. If these remedies produce very little irritation and the disease does not yield, the treatment used for a child of six or seven is tentatively tried. In the child of six or seven the epidermis of the scalp has usually become strong and the hairs are deeply rooted. In children of this age and older the disease is apt to be very obstinate. It is hardly practicable to make a distinction in the strength of the applications suitable to the different ages after seven. Some chil-

dren of nine or ten have the scalp so easily irritated that they cannot bear an application which in other children of five produces little or no effect. It is at this stage that the strength of the carbolic-glycerine and of citrine ointment (when this remedy has been used) must be gradually increased. At the first sign of a suppurative inflammation or rawness, they must either be weakened, or, if the symptoms are acute, boracic ointment is substituted for a few days, until the inflammation has subsided.

He is satisfied from experience that, as a rule, nothing is to be gained by producing too acute an inflammation on the surface of the scalp. The degree of inflammation which seems best adapted to effect a safe cure is indicated by a moderate erythema, which is kept up persistently for some time.

Citrine ointment, properly handled, is one of the most reliable remedies. He has known cases cured by it with scarcely any signs of inflammation being produced. He does not believe that this was due to any so-called parasiticide effect of the ointment, but to the production of chronic congestion to a moderate extent in the tissues around the hair-follicles. A deeper-seated congestion of the hair-follicles, is the effect which we wish to produce.

In dealing with older children, carbolic glycerine and citrine ointment may very fairly be tried before changing treatment. The former remedy alone may be effective. He does not question the utility of other preparations of mercury, as the oleate, turpeth mineral, white precipitate ointment, red oxide or perchloride of mercury. He sometimes employs blisters but never in young children. He does not favor epilation, as he says that when the hair is left in it keeps the mouth of the follicle pervious and insures access of the application to the spores. He thinks the good effects accruing from spirit lotions are due to the action of the alcohol. Tar, boracic acid, oil of cade, thymol, iodoform, eucalyptus, salicylic acid, and iodine he considers very uncertain remedies. Chrysophanic acid, turpentine, pyroligneous acid, croton oil, and goa powder he thinks too unmanageable. Electrolysis is advantageous where only few hairs are diseased.—*Practitioner*. July, 1887.

Beatty (W.) on a Case of Pityriasis Rubra.—The points of interest in this case, in addition to the rarity of the disease, seem to be:

1. The advanced age of the patient. She was seventy-one.

2. The rapidity with which the disease disappeared under the use of arsenic and bromide. Certainly she got iodide of potassium as well, but it was not given until after improvement had already begun. It may be noted that improvement had already begun before local treatment was commenced. The local treatment was limited to baths, soap and zinc ointment.

3. The fact that with the disappearance of the cutaneous affection mental derangement occurred.

The universal involvement of the skin, its freedom from moisture, and the fact that the scales were exclusively exfoliated epidermis, seem to distinguish the affection from eczema, to which disease it bore the closest resemblance.—*Dub. Four. Med. Sci.*, July 1, 1887.

Welch (G. T.) on Eczema Rubrum of Infancy.—The cases I have seen have occurred in the underfed and neglected infants of poor and sordid families, and a radical change must be made in the hygienic surroundings. Sour and filthy clothing must be removed, diapers must not be pinned about the child, but the discharges must be received upon napkins laid under the patient, which must be at once changed, and the parts must be gently bathed and dried afterward. Infants with this disease protest vigorously against the contact of water, and it does prove an irritant. Bran-infusion, or water to which glycerine and extract of witch-hazel have been added, or oatmeal-water, is best for bathing purposes, and, after drying, a powder of starch and oxide of zinc may be dusted over the surface. To the denuded part an ointment of glycerole of boracic acid is peculiarly grateful and healing. Spread upon prepared lint and laid over the part is the best way of employing it. Elsewhere lotions containing calamine and oxide of zinc in rose-water or lime-water prove most serviceable. Later on, ointments of oxide of zinc, and finally of mercurial preparations, are more useful.

Internally, emulsions of cod-liver oil, if they do not impair the already weak digestion, are called for, but especially mixtures containing pepsin, dilute hydrochloric acid, and bismuth, with a small amount of opium in some form, suspended in syrup and water, to check the indigestion and diarrhoea. This must be speedily controlled or

all is lost. If the mother's milk is unfit for nourishment, condensed milk, with lime-water, barley-water, and a few drops of whiskey, must be substituted. Some soluble food, or some approved preparation of beef, will find its place. The practitioner will be puzzled time and again, but an extended knowledge of the therapeutics of intestinal indigestion and of eczema will bear him out.—*N. Y. Med. Record*, June 25, 1887.

Crocker (H. R.) on the Treatment of Obstinately Recurring Eczema.—

In a bad case various kinds of treatment were tried, both internal and external, including that refuge of the destitute, arsenic, but although temporary improvement was obtained, so that the discharge and hyperæmia diminished, and he seemed to be getting well, in a few days out came the eruption as badly as ever, chiefly on the face and arms. Without in any way altering the treatment previously employed (feeling that I could not possibly make the eruption worse) I painted liq. epispticus on the nape. Owing to the thick scales the blister did not take, and it was repeated after cleaning the surface, and a good blister formed; a fresh acute attack was just threatening, but it did not come on, and the patient felt better. Three days later, the part having healed, the blister was repeated and there was evident improvement after it; the scales were less and the irritation was much relieved. The patient continued to improve, but the rash threatening again, another blister was produced. This, however, did not stop the rash, which came out freely, but the itching was much less than usual, and the eruption lasted but a short time, and from that time he continued to improve and went out almost well, and was able to go to work for five months, but having to keep his hands much in water it then returned. Encouraged by this result in a very unpromising case, I have extended the treatment, but using milder counter-irritants, such as mustard plasters or mustard leaves, instead of blisters, which were unnecessarily severe.—*Br. Med. Four.*, July 9, 1887.

Keegan (P. J.) on a Case of Multiple Vesicular Purpura.—A child, three and a half years old, usually of good health, had pneumonia of both lungs, which ran a favorable course. Two weeks after resolution had begun, spots appeared, apparently deep beneath the skin, from an eighth to a

quarter of an inch in breadth. They were faint blue at first, becoming darker, slightly elevated, and larger. They were first noted about the roots of the hair and scalp; later they appeared on the arms, legs, and body, also on the face, conjunctiva, tongue, and fauces. These spots probably existed throughout the alimentary canal, as hemorrhages from the bowels took place on the fifth day and continued at intervals for three days. When these purple spots had progressed to the surface of the skin, they were found to contain dark fluid blood, and if cut, the blood flowed over the surface. Where the eruption was not interfered with, the blood dried and came away in dry dark scales. For about two weeks the spots continued to appear in new localities, as the old ones disappeared. The child was then very weak and anæmic, but began again to convalesce, and made a good recovery.—*Albany Med. Annals*, June, 1887.

Keratosis Pilaris.—This is a cutaneous affection which is comparatively common, and known also as lichen pilaris. It consists of a number of discrete conical elevations of the size of a pinhead. They are of a whitish or gray color, as a rule, although frequently surrounded by a red areola, which gives the lesions the appearance of dark-red papules. The skin between these conical elevations is dry in character and appears harsh and scaly. If the hand be lightly passed over the affected portion a grating feeling is imparted, and this has been very aptly compared to that experienced in passing the hand over a nutmeg grater.

The extremities are the localities most often invaded, and of these, the extensor surfaces are the seat of predilection. I have found the extensor surfaces of the thighs to be the locality most often involved. The arms and forearms are frequently invaded and sometimes the trunk is also. It is only those parts which are supplied with hairs that are liable to this affection, and only those where lanugo hairs or very short and fine hairs are found.

The treatment is very simple. It consists in giving warm or vapor baths, or what is, perhaps, preferable, the Turkish bath. To cause a more rapid disappearance of the scales, the application of *sapo viridis* during the bath, or of alkalies, well diluted, is of signal benefit. Where the case is old, rubbing in well bland oils or

fat will prove a useful adjuvant. The treatment must be persisted in for a long time, and bathing regularly indulged in to prevent a return.

The prognosis is fair if due cleanliness be observed; but the patient, once the subject of this disease, is prone to relapses, unless he exercises diligence in the pursuit of cleanliness.—Editorial, *St. Louis Med. and Surg. Jour.*, May, 1887.

Elliot (G. T.) on the Histology and Pathology of Herpetiform Hydroa.—Herpetiform hydroa is an affection which owes its origin to a degenerative process situated in the nerves supplying the affected skin, and there is every reason to consider it as being trophoneurotic in its nature.

As a result more or less grouped vesicles and small bullæ form, which are directly connected with the sweat-ducts, and through them with the sweat-glands.

The point of origin of these lesions is primarily in the epithelium of the sweat-ducts, just below the horny layer of the epidermis, extending from there to the cells of the rete Malpighii.

The affection is accompanied by the ordinary symptoms of inflammation, which, however, are secondary and situated especially in the papillary layer of the corium.

Its histogenetic and pathogenetic characteristics are sufficiently distinctive to entitle it to be considered as a disease which is separate from all others.—*N. Y. Med. Jour.*, April 23, 1887.

Ohmann-Dumesnil on Erythematous Lupus of the Hands.—Existing upon the hands alone this disease is extremely rare.

Dr. Dumesnil relates the history of a case in which the lesions appeared upon the hands alone, had existed for a long time, and had been treated by caustic applications without much benefit. He employed concentrated lactic acid in the form of a paste, which produced severe pain, and was followed by a slough; pyrogallie acid was also used, but the case passed from observation before a cure was effected. The author has collected forty-five cases. In twelve the disease began in the face, the hands being subsequently affected. The lesions do not extend beyond the nails, and the dorsal surface is the seat of predilection. The patients were usually in good health. Dr. Dumesnil had endeavored to find cocci in the scales and sec-

tions of lupus erythematosus, but had not been successful. There is at first an inflammation of the epithelial layer, which subsequently dips down into the hair-follicles, following and affecting the epithelial structures, and only extends to the dermic structures by contact.—*N. Y. Med. Record*, Sept. 10, 1887.

Hyde (J. N.) on Three Cases of Simultaneous Hand and Foot Disease.—*Case 1.*—C. B., æt. 19, family history good; denied specific disease; three years ago noticed the first signs of the present affection on the fingers and later on the toes. The disease then extended to the palms of the hands and the soles of the feet. The local affection had gradually increased, and he complained of the stiffness thereby induced. The free border of the nails was tilted away from the fingers, and the space thus left was filled with hardened matter. The substance of the nail was dry and rugous. He had recently noted some sweating of the hands. The palms of the hands and soles of the feet presented a condition of tylosis. The nails of the toes were tilted away from the phalanges, and presented a condition similar to that seen in the nails of the fingers. There was also bromidrosis.

Case 2—A female, æt. 24; family history good, presented tylosis of the hands and feet, which continually recurred. The pulse was 50 a minute in the sitting posture. The hands were cold and bathed with profuse perspiration. The finger-nails were somewhat rugous, and tilted from the fingers, and the space filled with grayish masses. The same condition existed in the nails. The palms of the hands and the soles of the feet were simultaneously involved, showing callosities. Every six or eight weeks there was a re-formation of the masses on the soles of the feet. At no time did the tissue beneath these masses present a sound appearance. Treatment with various measures, continued for a long period, had no apparent effect.

Case 3.—Male, æt. 28, with a good family history and no history of syphilis; for two years had noticed some numbness of the lower extremities, especially marked at night. There was entire absence of hair on certain parts of the lower extremities. He stated that 15 years before, he had been struck on the head with a brick, and that a few years before coming under observation an operation had been performed upon the head, the exact nature of which he

could not state. The hands and feet were habitually cold. Broad vertical areas, chiefly on the outer aspects of the limbs, were found, in which not a single filament of hair could be detected. Two of the finger-nails of the right hand showed marked vacuolations.—*Four. Am. Med. Ass'n*, Sept. 10, 1887.

Tucker (J. L.) on Herpes Omo-brachialis.—The patient was a male, aged 36. He was of a family every member of which had been afflicted with some form of nervous disorder. When he came under the author's care five years ago he was emaciated, anæmic, and suffering with profuse diarrhoea. His habits were, and had been for some time past, good in every respect. His principal trouble was a cough of deep, sepulchral sound, which gave him no rest night or day. No mucus or other foreign matter was expectorated. On the 2d of December there was a neuralgic pain in the right shoulder; on the next day an eruption appeared there, attended with an almost insufferable sense of intense heat. The vesicular eruption was fully developed by the 9th, and occupied the shoulder and outer aspect of the arm, following the branch of the brachial plexus and terminating in an immense boil on the ball of the thumb. These vesicles passed through the various stages of irritation, inflammation, and resolution, and had entirely disappeared by December 15th. And still more remarkable, the chronic cough disappeared altogether. To relieve the pain and burning sensation, I used hot fomentations and oleate of cocaine and ointment of glycerine. It was no use to employ opiates, for although the patient was nervous and sleepless, morphia had no effect upon him. He took 240 grains of chloral hydrate of his own accord at a single dose, without any other effect than to make him slightly delirious.—*Cincinnati Lancet-Clinic*, April 30, 1887.

Robinson (T.) on Prurigo.—The author sums up his observations by the following postulates:

I.—There is not such a disease as *prurigo*.

II.—That all cases of itching skins have a recognized and discoverable cause.

III.—That all the group of symptoms which are known as prurigo are the result of scratching, and are simply symptoms.

IV.—All scratched skins which have advanced to an elephantoid state, and which

have set up enlargement of lymphatic glands, are beyond the reach of remedies or hope.

V.—That the pruriginous skin of children has its origin in developing hair follicles, which progresses from birth to puberty, when it stops.

VI.—That excessive itching does not occur in those situations where the hair grows luxuriantly.

VII.—That what is known as winter prurigo is due to imprisoned hairs.

VIII.—That an irritable state of the skin is always associated with an irritable state of the mucous and synovial membranes.—*Four. Cut. and Genito-Urinary Diseases*, July, 1887.

DISEASES OF THE NOSE AND THROAT.

ABSTRACTS AND SELECTIONS BY
C. H. KNIGHT, M.D.

Cartaz (A.) on Nasal Tuberculosis.—The author gives the history of a case of his own, and follows with notes of cases to the number of seventeen, reported by various observers, among them Schäffer, Laveran, Riedel, and Weichselbaum. The case reported by Cartaz was already well advanced in phthisis when she came under his observation. Aphonia, dysphagia, profuse night sweats, excessive cough, with abundant purulent expectoration, were prominent symptoms. There were cavities at both apices. The epiglottis was thickened and ulcerated. The arytenoids were swollen and infiltrated. The vocal bands were swollen, infiltrated, and ulcerated. The patient called attention to the fact that the nasal discharges were stained with blood. Examination of the nasal fossæ discovered an ulcer, the size of a twenty-franc piece, upon the left side of the septum, one centimeter from the nasal meatus. The removal of a bronchial crust was followed by a little bleeding, and exposed a reddish-gray surface covered by small prominent granulations. Behind this ulcer were several small yellowish prominences and ex-ulcerations. The septum was not perforated. The mucosa otherwise was unchanged, except, perhaps, somewhat hyperæmic. The right nostril was free from disease. In the course of a few days the patient succumbed to her pulmonary disease. No examination for bacilli was

made, but the appearances of the ulceration and the concurrence of laryngo-pulmonary tuberculosis leave no doubt in the mind of the author as to the character of the nasal lesion.

In not one of Schäffer's cases, six in number, were lesions of the larynx or lungs discovered. In two the family history was free from tubercular taint. In two cases histological examination by Nasse showed the characteristics of a tubercular tumor, composed of granulation tissue, giant cells, and a few bacilli. The second observation of Schäffer is of interest from the fact of the concurrence in the same nostril of myxoma and tubercular tumor, the former springing from the turbinated bodies, the latter from the septum. Evidently this lesion is extremely rare. Willigk has found 1 case in 476 autopsies, and Weichselbaum 2 cases in 164 autopsies of tubercular subjects. In the eighteen cases collected by the author, the ages of the patients ranged from 15 to 63 years, and the sexes were about evenly divided. In the majority of cases there was evident hereditary taint, but in surprisingly few cases was tuberculosis of the upper air and digestive tracts found to co-exist.

Nasal tuberculosis exists under three principal forms: (1) ulcerating; (2) vegetating (tubercular gumma or granuloma); (3) lupus. The last-mentioned, the identity of which with tuberculosis is still by no means established, requires no consideration from the author, who refers to the thesis of Moinel (*Du lupus scrofuleux des fosses nasales, Thèse de Paris, 1877*), and to an article by Cozzolino. The first two varieties, tubercular ulcer and tubercular granuloma, or tumor, may co-exist. The onset of the disease being insidious, it is rarely seen by the physician until the ulceration has already become quite extensive. In the neighborhood of the margin of the ulcer may usually be found deposits constituting the first manifestations of the lesion.

Generally the ulcer is found upon one side only of the septum; it sometimes extends to the floor of the nose, or it may invade the skin of the upper lip. At its periphery are seen the deposits referred to, grayish-yellow granulations identical with those occurring on the tongue, and described by Trélat and Juillard. These yellowish granulations are of very great

diagnostic importance. There is little or no bleeding except on forcible removal of the crusts, which are prone to form, and pain is generally absent.

Aside from signs furnished by examination of the lesion, slight hypersecretion, and impediment due to accumulation of crusts, the ulcerative form of tubercular disease may be said to occasion no particular symptoms. The second variety of tuberculosis, especially observed by Koenig, Riedel, and Schäffer, is sooner or later productive of decided nasal stenosis, and occasionally of pain, localized or radiating. Schäffer believes that these tubercular tumors always spring from the septum. They are pale-red in color, have an irregular, granulated surface, and are frequently ulcerated. They are of soft consistence, almost friable. The diagnosis of nasal tuberculosis, in the absence of laryngo-pulmonary disease, may be difficult. The situation of the lesion, the presence of circumferential yellowish granulations, and the actual demonstration of tubercle bacilli indicate the nature of the disease. The treatment of the nasal lesion need not be abandoned, even though generalization of the disease may be suspected. In the case of a tubercular ulcer, the surface should be burned with the galvano-cautery, or with lactic acid (20 to 50 per cent.) under cocaine (15 to 20 per cent.), and then dressed with iodoform. Tubercular tumors may be removed with the knife or the galvano-caustic loop. The surface left should be curetted and dressed with iodoform. (*France Méd.*, Nos. 84, 85, 86, and 87, 1887.)

Eight cases reported by Schäffer and Nasse may be found in the *Deutsche Med. Wochenschr.*, No. 15, April, 1887, histories of six being given in full. They were met with in a collection of more than 450 cases of nasal tumor. The character of the disease was proved in two cases by detection of tubercle bacilli. In three cases perforation of the cartilage occurred. The tendency of the lesion was backward, and in one case the bony septum was involved. There were in no case signs of laryngo-pulmonary tuberculosis. In old cases the opposing surfaces of the middle and inferior turbinated became affected, as well as the floor of the nose anteriorly. No external manifestations were present. (See also, Tuberculosis or Lupus of the Nasal Mucous Membrane: M. Bresgen, in *Deutsche Med.*

Wochenschr., No. 30, July, 1887, and answer by Schaeffer, in same journal, No. 32, Aug., 1887.)

Duret on Epithelioma of the Nasal Fossa.—In the *Four. des Sciences Méd. de Lille*, Sept., 1887, a case of this rare lesion is reported. The patient was seventy-five years of age, and for two months had been treated for nasal myxoma. The hemorrhages following removal of the tumor, which was attached to the superior turbinated body, was so profuse that suspicion as to the character of the growth was finally aroused. Soon phlegmonous inflammation developed below the margin of the orbit, followed by a well-marked indurated tumor. Resection of the anterior part of the superior maxilla was performed with a satisfactory result. From this case the conclusion is drawn that methodical examination of the nasal fossæ is necessary for diagnosis. In some cases careful examination of the ulceration of the turbinated body might demonstrate its nature. In the case reported this would have been impossible, since the ulcer was situated on the upper face of the superior turbinated body. The extraordinary vascularity of the tumor and the presence of a vegetating mass, in place of a typical polyp, cleared away the difficulties of diagnosis.

Casselberry (W. E.) on Nasal Fibromata.—A paper with this title was read before the section in laryngology of the International Medical Congress, in which was given a tabulated list of all the cases on record. The author also gave the history in detail of a case of his own, which was successfully treated by removal of portions of the growth at various times by means of the cautery knife and loop. Steel piano wire was used instead of platinum, for the reason that it is stiffer, and hence easier to apply. Cocaine, in twenty per cent. solution, prevented pain. The use of a weak solution, followed by stronger ones, if tolerated, thoroughly applied, was strongly urged, and it was especially advised not to attempt the removal of too much of the neoplasm at one time.—*N. Y. Med. Record*, Sept. 17, 1887.

Young (Gilbert) on Obliteration of the Orifice of the Nose.—The deformity was the result of destructive syphilitic ulceration. An interesting point in the clinical history was the almost complete relief from distressing attacks of spasm of the glottis which had previously occurred, fol-

lowing a simple operation to re-establish nasal respiration.—*Med. and Surg. Rep.*, Oct., 1887.

Bridgman (H. E.) Lodgment of a Toothplate in the Gullet for Fifteen Months.—It does not seem quite clear, from the clinical history, exactly where this foreign body, a small plate to which were attached four teeth, hid itself for so long a time. At any rate, while the patient was sleeping, it slipped from its usual position into the pharynx. Very shortly attempts were made to dislodge it by means of probangs and forceps. Once it was seized, but the patient was suffering from dyspnœa and struggled; the forceps slipped and could not again grasp it. The probang was passed into the stomach without meeting with obstruction. The dyspnœa and dysphagia passed away in a few days. Fifteen months later, the patient meantime having suffered more or less from dyspnœa and cough with bloody expectoration, he had a violent fit of retching, felt something in his throat, and by means of his finger hooked out the teeth. The subsequent history of the case is not given.—*London Lancet*, Sept. 24, 1887.

Browne (Lenox) on an Unrecognized Cause of Many Throat Ailments.—In an address delivered before the Phila. Co. Med. Soc., Mr. Browne drew attention to two neglected conditions: (1) Varicosity of the veins at the base of the tongue on its dorsum, and often on its under surface and sides, in the latter situation being symptomatic of mitral insufficiency, or of severe hepatic derangement, or even of cerebral lesion. A similar condition of the veins on the upper surface of the epiglottis may also be found. (2) Enlargement of the circumvallate papillæ at the root of the tongue, impeding or entangling the epiglottis. If the case is not of long standing or of aggravated character correction of the main constitutional cause—cessation of the faulty method of voice production, or prohibition of a vicious habit or indulgence—may be sufficient to effect a cure, but this is rarely the case. Of remedies, I give chalybeates and aperients with digitalis or ergot, as may be indicated. Locally, astringent applications, especially chloride of zinc or perchloride of iron, are by no means without avail; they can be applied by the patient himself. Gargles as ordinarily employed are useless, and occasionally are productive of exacerbation

of the symptoms. Not so if employed by the method known as that of Von Troeltsch. Of lozenges, I find those of muriate of ammonia much more active in leading to resolution of the venous congestion, than those of red gum, rhatany, etc.

Recent investigations show that the astringent properties of tannin have been exaggerated. Where the uvula is relaxed, the snipping of an elongated portion, especially if other functional or constitutional faults are corrected, may lead to a cure; but in a certain proportion of patients in which the promises of the specialist as to the good effects to be gained by the procedure are not realized, the cause of failure will be found in non-recognition of the varicose vessels. Treatment of these is best effected by the galvano-cautery point, and it is necessary to seal each individual enlarged vessel. For this purpose it may be necessary to make more than one application. Lastly, there is often a hyperæmic tumefaction of the vessels, glandules, and submucous tissues of the pharynx, naso-pharynx, and turbinated bodies; these will also be treated by galvano-cautery.—*Med. and Surg. Rep.*, Oct., 1887.

Epithelioma of the Epiglottis Removed with an Epiglottome.—This case, occurring in the service of Dr. Morell Mackenzie, is reported by Dr. R. C. Myles, and is of interest from the method of operation employed. The instrument used seems to resemble a tonsillitome, except that its cutting end is curved, in order to permit the fenestra to pass well down to the base of the epiglottis. In the case reported cocaine was used; there was no pain, and bleeding was very slight. After hemorrhage had ceased, one quarter of a grain of morphine was applied to the stump. The next day the patient could swallow solids without difficulty, and by the end of a month even fluids would not enter the larynx during deglutition.—*New Orleans Med. and Surg. Jour.*, Oct., 1887.

Johnson (H. A.) on Cancer of the Larynx.—Five cases were reported in a paper presented to the American Laryngological Ass'n at its ninth congress. The author closes his paper as follows:

In conclusion, I beg to call attention to the facts:

1. That all of the five patients were males, the youngest forty-five years old.
2. That of the five cases, the growth was evidently from the right side in three

cases, from the left side in one case, and in the remaining case probably from the left side.

3. That in only one case was there a history of cancer in the family, in the mother of the patient (Case V).

4. That in one case the disease seemed to be secondary or an extension of an external cancer.

5. That in one case only was there any evidence of infection of the lymphatics from the larynx.

6. That in only one case was there any troublesome hemorrhage.

7. That in none was there marked pain in the larynx.

8. That in three cases tracheotomy was performed, and the patient's lives were prolonged apparently three, five, and eight months respectively.—*N. Y. Med. Jour.*, Sept. 24, 1887.

Charazac (J.) on a Case of Laryngeal Polypus; Spontaneous Expulsion; Recovery.—A woman of thirty-one had complained for ten years of rheumatic pains and hoarseness. She was found to have a laryngeal polypus the size of a small strawberry, and of firm consistency. The growth gradually increased, as did the embarrassment of respiration, and the voice became extinct. During the winter of 1886 the patient, during a violent attack of coughing, ejected the mass. Six months later all traces of the tumor had vanished, and respiration and phonation were normal.—*Gaz. des Hôp.*, Oct. 6, 1887.

R. W. A.

Macdonald (G.) on Idiopathic Intra-Laryngeal Abscess.—The clinical histories of two cases are given. In the first the abscess involved the right ventricular band, and at the same time there existed congestion and oedema of the right vocal cord and of the interarytenoid fold. In consequence, there ensued extreme laryngeal dyspnoea, which was in great measure relieved by puncture of the abscess. Antisyphilitic treatment was at the same time employed, since the posterior wall of the pharynx displayed well marked cicatrices. Although there was no history of syphilis, it was supposed that the abscess might be a suppurating gumma. Improvement was very rapid. In the second case the abscess was seated in the right aryepiglottic fold, and appeared to rest upon the ventricular band. To the probe it appeared soft and fluctuating. With the la-

ryngeal lancet pus was evacuated, and the prominence collapsed. The pain on swallowing was immediately relieved. A benzoic acid inhalation was prescribed. At the patient's next visit, a week subsequently, all traces of the inflammatory mischief had disappeared.

The second case is quite of minor interest save from its rarity. Idiopathic laryngeal abscess is scarcely discussed by authors. Morell Mackenzie has collected thirteen cases. Of these six occurred at the root of the epiglottis, four involved the ventricular bands, and three the aryteno-epiglottic folds. Nine were opened, the remainder undergoing spontaneous rupture.—*London Lancet*, Sept. 24, 1887.

O'Dwyer (J.) on Treatment of Chronic Stenosis of the Larynx and Trachea by Intubation.—The fact that stenosis in diphtheria is due to submucous thickening as well as to the presence of false membrane was demonstrated upon specimens of healthy and diphtheritic larynges. It was also shown that the calibre of the small tubes is proportionately larger than that of tubes used for adults, an objection which has been urged to the tubes adapted to children being thus disproved. Histories of several cases of subglottic stenosis, successfully treated after the failure of tracheotomy, were read. The author also exhibited a laryngeal speculum and a snare for removal of membrane and small papillomata from below the vocal bands.—*N. Y. Med. Rec.*, Sept. 17, 1887.

MISCELLANEOUS.

Byford (H. F.) on the Pelvic Viscera of an Infant, Three Days Old.—The bladder was in front, and the uterus situated behind and to the left side, directly in front of the rectum. The lower end of the cervix was decidedly to the left, as we often find it in the adult. The uterus was constituted of about one fourth corpus, and three fourths cervix; the cervix was also wider and thicker than the body. And what was also characteristic, and was first noticed by Winckel, the Fallopian tube, ovarian ligament, and broad ligament on the side towards which the uterus is placed, were shorter than the tube and ovarian ligament on the other side, showing that in this case the normal position of the cervix

is to the left of the median line. There was also a slight persistent ante flexion. The rudimentary ovaries were almost against the uterus, and the right one and one half times as large as the left. The cervical cavity was quite large and contained mucus. The cervix extended considerably below the *cul-de-sac* of Douglas. The uterine artery entered the uterus a little above the middle of the cervix, considerably below the upper end of the cervical cavity. It is also interesting to note that the arteries upon the right side were larger than on the left. The uterus had a slight inclination from the cervix up towards the right and towards the median line, and thus already exhibited a slight lateral version such as we see in adult life. The vesico-uterine and sacro-uterine folds were well developed.—*Am. Jour. of Obstet.*, etc., Aug., 1887.

Gant (F. J.) on Two Cases of Disease at the Sacro-Iliac Synchondrosis.—The symptoms were: swelling over the sacro-iliac joint, which went on to fluctuation; pain on deep pressure, and running down towards the hip; a sensation of giving away; apparent elongation of the limb, but no real lengthening when measured from the anterior superior iliac spine to the inner malleolus; abduction and eversion of the limb and a slight forward projection of the foot; and the anterior iliac spine prominent and on a lower level than the other. Often in sacro-iliac disease there is a wriggling movement in progression. The abscesses were evacuated, and the joint and abscess cavity scraped with a Volkmann's spoon, and treated antiseptically. In from one to two months they were able to walk comfortably.—*London Lancet*, Aug. 27, 1887. J. R.

Gleditschine or Stenocarpine.—Investigations of specimens of this new remedy, obtained of Messrs. Lehn and Fink, of New York, at the laboratory of Messrs. Parke, Davis, & Co., appear to prove the said remedy to contain 6 per cent. of cocaine and probably some sulphate of atropia, while the leaves of the Gleditschin triacanthus, from which the stenocarpine is supposed to have been derived, contains but a very small quantity of an alkaloid, and that without active anæsthetic properties. Is the new remedy an attempted imposition upon the medical profession?—*Jour. Amer. Med. Ass'n*, Oct. 29, 1887.

BOOK NOTICES.

A Practical Treatise on the Diseases of the Hair and Scalp. By George Thomas Jackson, M.D., Instructor in Dermatology in the N. Y. Polytechnic. New York, E. B. Treat, 1887.

Dr. Jackson is to be complimented on being one of the few medical authors who has written a book to supply a want which really existed in a marked degree. He, as well as others, has experienced the need of a clear and comprehensive treatise on diseases of the hair and scalp, and we think that he has fulfilled his aim in this book of presenting "a concise statement of what is known of these diseases."

As showing the thoroughness of Dr. Jackson's work we quote the following titles of the various chapters: Anatomy of the Hair, Physiology, Hygiene, Canities, Changes in Color, Alopecia, Alopecia Areata, Atrophia Pilorum, Hypertrophia, Trichiasis, Sycosis, Trichophytosis, Kerion, Favus, Pediculosis Capitis et Corporis, Unusual Parasitic Diseases, Dandruff, Keratosis Piloris, Eczema Capitis et Barbæ, Plica Polonica, Dermatitis Capillitii, Nævus Piloris, Syphilis, Lupus, and Vitiligo.

Besides these chapters there is a bibliography embracing twenty-six pages, which is very complete and shows wonderful industry on the part of the author. The clinical history of the various affections is given in a clear and concise manner, the sections on diagnosis and prognosis are excellent, while those on treatment, which contain the personal experience of the author as well as that of all authorities, is worthy of much praise.

The illustrations are numerous and will be of much service to the reader, and the type is large and clear.

Dr. Jackson has produced a capital book, and we feel assured that it will have a large circulation. R. W. T.

The Physician's Visiting List (Lindsay & Blakiston's), Thirty-seventh Year, 1887-1888, with Many Improvements. P. Blakiston, Son, & Co., Philadelphia.

Strength, compactness, convenience, and durability are the essential qualities which a good Visiting List should possess to resist the unusual hard wear it receives. These qualities are all combined in Lindsay & Blakiston's "Physician's Visiting List," which has now been published for thirty-seven years. It is the most convenient for the pocket. Its contents are arranged in the most advantageous way, including the following useful tables and specific information: A Calendar for 1888 and 1889.

Table of Signs to be used in keeping accounts.

Marshall Hall's Ready Method in Asphyxia.

Poisons and Antidotes.

The Metric or French Decimal System of Weights and Measures.

Dose Table, revised and rewritten for 1888, by Hobart Amory Hare, M.D., Demonstrator of Therapeutics, University of Pennsylvania.

List of New Remedies for 1888, by same author.

Aids to Diagnosis and Treatment of Diseases of the Eye, Dr. L. Webster Fox, Clinical Asst. Eye Dept. Jefferson Medical College Hospital, and G. M. Gould.

Diagram Showing Eruption of Milk Teeth, Dr. Louis Starr, Prof. of Dis. of Children, University Hosp., Phila.

Posological Table, Meadows.

Disinfectants and Disinfecting.

Examination of Urine, Dr. J. Daland, based upon Tyson's "Practical Examination of Urine." (5th Ed.)

Incompatibility, Prof. S. O. L. Potter, Author of "A Hand-book of Materia Medica and Therapeutics." A New Complete Table for Calculating the Period of Utero-Gestation.

Sylvester's Method for Artificial Respiration. Illustrated.

Diagram of the Chest.

Anæmia.—By Frederick P. Henry, M.D., Prof. of Clinical Medicine, etc., etc. Pp. 134. Price, 75 cents. P. Blakiston, Son, & Co., Phila.

This, the first systematic treatise on anæmia published in this country, is a reprint of a series of articles published in *The Polyclinic* during the past year, and embodies the results of many years' study of the blood and the disorders consequent upon its imperfect elaboration. The statements which it contains are, for the most part, based upon personal observation, and where this has been wanting, upon accepted facts of physiology and pathology. The author has endeavored to supply the want of a trustworthy guide to a wide and growing field of research—a want which he himself has keenly felt.

Manual of Clinical Diagnosis.—By Dr. Otto Seifert and Dr. Friedrich Müller. Third edition, with sixty illustrations. Pp. 173. Translated by William Buckingham Canfield, A.M., M.D., Fellow of the American Academy of Medicine, etc., etc. G. P. Putnam's Sons, New York and London.

The translator, in the preface, says: "The favor with which this book has been received in Germany, and its eminently practical and concise manner of dealing with the different important points in diagnosis, seem to justify its translation into English. It has been brought down to the latest acquisitions of science, thus representing the most advanced views."

The authors' endeavor has been to give "in an epitomized form, the different methods of examination, as well as a convenient collection of those data and figures which should always be familiar to the physician and student." That this has been well done a perusal of the pages of the book will show.

Differential Diagnosis: a Manual of the Comparative Semiology of the More Important Diseases.—By F. de Havilland Hall, M.D., etc., etc. Third American edition, thoroughly revised and greatly enlarged. Edited by Frank Woodbury, M.D., etc. 8vo., pp. 255. D. G. Brinton, Phila.

The contents of this book are outlined in its title. It does not pretend to treat of the differential diagnosis of *all* diseases, but wisely confines itself to the commoner, more important ailments.

The differential diagnostic points are arranged, in many instances, in parallel columns.

The author first takes up general diseases, of which he makes two groups only—fevers, and diseases of the blood. In the second part of the book the author takes up local diseases, using a physiological rather than an anatomical classification.

The work, on the whole good, is not free from errors, as a glance at page 103 will show—where, a disease is located "in the termination of the cord low down in the sacral canal," and "in the cord at the upper limit of the sacral region," every first-year medical student knowing that the spinal cord does not reach the sacrum at all.

The Annals of Gynecology: a Monthly Review of Gynecology, Obstetrics, and Abdominal Surgery. Edited by E. W. Cushing,

M.D., Boston, Mass., with the collaboration of Profs. T. G. Thomas, W. G. Wylic, W. K. Polk, Dr. Laskie Miller, and Dr. Andrew F. Currier.

The first and October number of this new journal has just appeared. The names on its editorial staff are a sufficient guaranty of its excellence. The original articles in this number are: Pathology of Erosions, by E. W. Cushing, M.D.; Lithopædion, by W. H. Fales, M.D.; Expulsion of Uterine Myomata, by A. F. Currier, M.D.; Aveloz in Uterine Cancer, by J. E. Janvrin, M.D.; and four editorials on various topics.

The publishers are Lockwell & Churchill, Boston.

Another new production is

The Journal of Morphology.—Edited by C. O. Whitman, Director of the Lake Laboratory, Milwaukee, Wis., recently of the Museum of Comparative Zoölogy, Cambridge, Mass. Crown 8vo. Two numbers a year of 100 to 150 pages each, with from five to ten double plates. Subscription price, \$6.00 a year; single numbers, \$3.50.

It is a journal of animal morphology, devoted principally to embryological, anatomical, and histological subjects. Cordial promises of support have been received from many of the most eminent investigators in this department. The *Journal* will be issued in the best style, with elaborate lithographic plates.

It is published by Ginn & Co., Boston, New York, and Chicago.

PUBLISHERS' NOTES.

Fats as Tonics.—Fats, especially those which are of easy digestion, like cod-liver oil and sweet cream, are also essential to the well-being of the nervous system. The peculiar substance—neurene—found in all nervous structures contains fat as an essential constituent. It is remarkable that most "nervous" individuals have a strong aversion to fats as articles of diet. This is extremely unfortunate, for the omission of fats and oils from the diet tends to not only continue the nervousness, but to increase the irritability and weakness. Cod-liver oil is a most valuable medicine in such cases, because it is already partly digested by admixture with the bile secreted by the liver of the fish, and thus rendered still more easy of absorption. The labor of digestion is thus partly taken away from the tasks to be performed by the invalid. The fishy and unpleasant odor and taste are objectionable, and many patients cannot take it; this difficulty is believed to have been overcome by Scott's Emulsion of Cod-liver Oil with the Hypophosphites, which is so palatable that it can be taken and retained by the most delicate, and as this Emulsion does not separate or change, the dose can always be depended upon to be alike.

Phillips' Emulsion of Cod-Liver Oil, by reason of its originality and distinctive features, attracted attention on its introduction in this market. It has stood the test of years, gained many friends in the profession, and has established its claims to minute division, miscibility, palatability, ease of administration, and assimilation. Physicians who have not examined this preparation will find it worthy their investigation and trial.

Celerina.—H. A. Spencer, M.D., Surgeon-in-Chief, Pennsylvania R. R. Co., Erie, Pa., says: I have used Celerina and am well pleased with the result. I find it a very valuable remedy in nervous cases, and in one case of mild insanity resulting from change of life, in which I had tried all the usual remedies with unsatisfactory results, I found the Celerina to control the difficulty better than any thing I had tried. The patient is still using it, and is, I am glad to say, improving. I am also using it in several cases of neurasthenia, insomnia, and impotency, with quite satisfactory results.

From my experience, I do not hesitate to commend it to the favorable notice of the profession.

Food for Invalids.—Hundreds of invalids fail to regain their health and strength because of inability to digest and assimilate their food. If they would use the Lactated Food, they would find it an article which is most easily digested, and will be assimilated by the stomach when all other foods fail. It is predigested, non-irritating, and has great nutritive properties. It can be prepared in many different ways, and is a palatable and delicate article of diet. Send for pamphlet, giving important medical opinions on the "Nutrition of Infants and Invalids," to Wells, Richardson, & Co., Burlington, Vt.

Retreats, Sanitariums, etc.—The attention of our readers is called to the different institutions advertised in this number of the ANALECTIC.

Prof. Loissette's Memory Discovery.—Prof. Loissette's new system of memory training, taught by correspondence at 237 Fifth Ave., New York, seems to supply a general want. He has had two classes at Yale of 200 each, 250 at Meriden, 300 at Norwich, 100 Columbia Law Students, 400 at Wellesley College, and 400 at University of Penn., etc. Such patronage and the endorsement of such men as Mark

Twain, Dr. Buckley, Prof. Wm. R. Harper, of Yale, etc., place the claim of Prof. Loissette upon the highest ground.

Invalids' Rolling - Chairs.—The United States Government has placed the chair manufactured by the New Haven Folding-Chair Co. of New Haven, Conn., in all the marine and other hospitals under its charge. Send for their price-list and descriptive catalogue, and mention the ANALECTIC.

Lactopeptine.—Send to the New York Pharmacal Association, P. O. Box 1574, for their new Medical Almanac, which contains valuable information for practitioners.

Iron-Alum Mass.—From Richard Lemmon, M.D., Lynchburg, Va.—Allow me to commend to the profession the use of the Waters and the Mass of the Seven Springs. For throat diseases and chronic nasal catarrh, taken systematically and as a local application, in connection with other local remedies, I find these agents of extreme value.

Syrup of Hypophosphites.—The success attending the use of the various oxides and salts of phosphorus in medicine has led to the manufacture of innumerable preparations of this class. Dr. McArthur's Syrup of Hypophosphites was among the first of these, and its superior purity and efficacy have enabled it to keep far in advance of its competitors.—*Popular Science News.*

Horsford's Acid Phosphate.—Dr. W. S. Leonard, Hinsdale, N. H., says: I have used Horsford's Acid Phosphate in my practice for the past eight or ten years, and have been much gratified with the results obtained from its use. In various forms of dyspepsia it reaches a class of cases that no other medicine seems to touch, and I have repeatedly seen patients, where opiates were contra-indicated, obtain refreshing sleep and rest at night from a single dose at bedtime.

Crystalline Phosphate.—GENTLEMEN: I have received a small package of your Crystalline Phosphate, and have been prescribing it in my practice, and find that it does every thing that it claims to do. I have also prescribed it for myself in chronic dyspepsia and nervous prostration, and find it is *par excellence* of the day as a nerve food and a nerve tonic.

WILLIAM TAYLOR, L.R.C.S.I. E.
Detroit, Mich.

THE MEDICAL ANALECTIC

A
MONTHLY EPITOME OF PROGRESS IN ALL DIVISIONS OF
MEDICO-CHIRURGICAL PRACTICE

EDITED BY
R. W. AMIDON, M.D.

VOL. IV., No. 12.

December, 1887.

WHOLE No. 48.

LEADING ARTICLES.

Penrose (C. B.) on Sulphate of Magnesia in Abdominal Distension and Peritonitis after Laparotomy.—The administration of a purgative for the relief of the abdominal distension and peritonitis which sometimes follow laparotomy was first advised by Lawson Tait. The treatment is also advocated by Greig Smith and by other surgeons abroad and in this country. There is at the same time a strong tendency among many physicians to adhere to the routine practice of administering large doses of opium as soon as any symptoms of peritonitis are manifest.

The abdominal distension which follows laparotomy is due to paralysis of the muscular coat of the intestine. In the simplest cases this distension lasts but a few days, and is caused by the diminished tonicity of the intestine muscles from exposure, manipulation, or relief from intra-abdominal pressure. In other cases it may precede or accompany peritonitis, and the muscular paralysis is caused by the inflammation of the serous covering of the intestine.

The results of abdominal surgery show that it is not necessary to paralyze the intestinal tract further by the administration of opium. The danger of moving the bowels after exposure of the peritoneum has been much exaggerated. It seems probable that the peritoneum is subjected to at least as much irritation from the tension and movement caused by the distending gas as it would be from any peristaltic motion of the muscles of the intestines.

A free, watery purge encourages peristalsis and the escape of gas. It depletes congested peritoneal vessels, and probably drains off, through the intestines, serum which was contained in the peritoneal cavity. The diminution in the quantity of the serum discharged from an abdominal drain-

age tube is often very marked after the administration of a free purge.

The choice of the purgative depends somewhat upon the nature of the case. When there is excessive vomiting it may be necessary to employ small, frequently repeated doses of calomel. In most instances, however, there is no better purgative than sulphate of magnesia. It produces large serous evacuations and no intestinal irritation. — *Med. and Surg. Reporter*, Oct. 22, 1887.

Baldy (J. M.) on Salines in Peritonitis Following Abdominal Section.—The subject of abdominal surgery has for the past few years been so freely discussed, and operators all over the world have been so busy collecting together such numerous statistics and perfecting details, that most of the operations performed to-day are fast settling down into their permanent positions in the surgery of the future. The technique of the several operations has been so thoroughly digested that there remains but little to be said in this connection, excepting in a few instances.

The subject of the after-treatment, however, has not been brought so constantly before the profession; and operators are apt to think it not worth while to bring little details which they deal with every day, and take as a matter of course, prominently forward and to notice. It is well known to surgeons that the management of these cases, after the operation, is of prime importance, and that many a life would here be lost but for the most careful and skilled treatment; and so the results of a seemingly perfect operation be annulled.

The particular phase of the after-treatment which I would urge upon the attention of the profession at this time is the management of those patients in whom peritonitis is beginning to develop or has already gained full headway. This dread

complication, arising when least expected, and sometimes after we have considered the patient out of danger, has in the past been reported as the cause of death in a multitude of instances ; in fact, twenty-five per cent. of the deaths following abdominal section are attributed by one writer (Agnew) to this cause. Even with our present perfected methods of operating, we still see this disease arising constantly. With this complication ever in mind, I have, since beginning to practise abdominal surgery, followed the example set by Mr. Tait, of never taking any steps to prevent a movement of the bowels after operation, and have fallen into the habit of routinely administering salines in small, often-repeated doses, sometimes as early as the second, generally on the third, day, provided the bowels have not been opened spontaneously at this time.

The results have been, without exception, most satisfactory. The patient has invariably been more comfortable after a passage has been secured, and in cases where a drainage tube has been used the discharge has been markedly lessened from the time the purge began to act. Where there is much persistent bilious vomiting present most gratifying results are obtained. I have yet to see a single unfavorable result arise from this treatment.

Dr. Wylie, of New York, taking the hint from Mr. Tait has been in the habit of opening the bowels by enemata and purgatives, "even during the first twenty-four hours after operation"; and he says, "when tympanites or eructive vomiting begins, I at once move the bowels by turpentine or ox-gall enemata, or by a seidlitz powder or Rochelle salts." Dr. J. Taber Johnston, in a paper before the recent International Medical Congress, has urged the same line of treatment in these cases; it has also been the course pursued by Dr. Price, of this city. So it would seem that surgeons are beginning to adopt the saline treatment in preference to the opium in cases where there arise the commencing symptoms of peritonitis. I would, however, go further than this, and urge that the same line of treatment be followed in cases where the disease is fairly well developed, and that at all hazards the bowels be induced to discharge free watery stools as soon as possible. It is surprising to see how quickly all symptoms begin to subside when this is accomplished. In cases of

distension, vomiting, elevated temperature, and quick pulse, etc., Mr. Tait gives small doses of magnes. sulph. every hour until the bowels are opened, and says: "If these symptoms advance to an alarming extent, I use still more active measures to get the bowels moved, *because I always find that as soon as a motion has passed they rapidly disappear.*" My own experience is in exact accordance with that of Mr. Tait, and the following case, which has only recently occurred, well illustrates the rapidity with which all symptoms abate under such management:

Mrs. S—, thirty-three years of age; three children; married ten years; last child five years ago. Has never been pregnant since this event; has always suffered since, and has been gradually getting worse; is only able to work a few days at a time. On September 13th I removed from the left side of pelvis an ovarian cyst as large as a good-sized orange, slightly adherent to pelvic walls and rectum; a cystic-degenerated ovary, and a beginning cyst of the Fallopian tube from the right side; a cyst containing about a drachm of straw-colored serum from the fundus of the uterus, not connected with either tube. As usual, on the third day her bowels were moved gently with salines, and she was doing as well as it is possible for a patient to do; she so continued until she had passed nine and a half days. The stitches had been taken out on the fifth day, and union found to be perfect. I had promised her that she might get up in three more days. I have since discovered that she had been getting out of bed for the past four or five days to shut doors, windows, and to have her bowels emptied. On the 21st of the month she complained of a slight soreness in the left ovarian region. On the 22d, however, she was feeling better, and had not so much pain as the day before. At eight o'clock that night I was summoned to her, and found her just coming out of a violent chill; abdomen slightly swollen; pain increased. She was ordered an ounce of Rochelle salts in divided doses, which she took during the night. In the morning I found she had slept none all night, and was then very much worse—alarmingly so. By noon her temperature and pulse were high, her abdomen extremely swollen and barrel-shaped, tympanitic, and so excessively painful that she could not stand the weight of the bedclothes; knees drawn up; anxious

expression of face; dry, parched tongue and lips; vomiting. The small doses of salts had not acted, and she was growing rapidly worse. Influenced by my experience in milder cases, as well as some most excellent results obtained by Dr. Charles Penrose in fully developed peritonitis, I administered an ounce of magnes. sulph. in a concentrated solution, and ordered the dose repeated twice more, at intervals of an hour and a half, should her bowels not be moved in the meanwhile. She was given both doses, besides receiving two or three large (several quarts) turpentine enemata. About two o'clock her bowels were slightly moved, and within the next thirty-six or forty-eight hours she had about fifteen large watery stools. From the time her bowels began to act she began to improve in every symptom—her pulse and temperature dropped; she never vomited after the second passage; by the next morning the swelling of the abdomen was markedly less; the tympanites had subsided to a very great extent, and her abdomen could be manipulated pretty freely without causing her much pain; her whole appearance was improved, and her countenance showed immense relief. She slept quietly almost the whole of that night, and went on steadily improving until final recovery.

Heretofore I have treated cases of peritonitis on the opium plan. In one case I gradually increased the dose of the tincture of opium until the patient received on one day between sixty and seventy grains of the drug. I have never been satisfied with this kind of treatment, nor have I ever been able to convince myself that it was even logical; it has heretofore been followed simply because all authorities recommend it and strongly condemn purgatives. The rate of mortality in peritonitis is terrible, and the results of the cases treated with opium will stand, I believe, in the future in marked contrast with those treated with salines. Practically, so far as tried, salines have proved themselves satisfactory beyond anticipation, and if such results are continued the time will come when opium will take the place now occupied by purgatives among authorities. Logically, salines are infinitely better than the narcotic. We are taught that opium "puts the bowels in splints," and in this manner keeps the peritoneal surfaces from rubbing together and increasing the inflammation. But the bowels are already in splints, as it were, and

any one trying to make them move will be quickly convinced of this fact—therefore for this purpose opium is superfluous. The drug relieves the pain, it is true, but oftentimes it does not even do this, except in enormous doses. Relief of pain is practically all that opium can do for good in peritonitis. It, however, does a world of harm—it helps to keep the bowels in splints, and so favors the formation of those great masses of adherent intestine which we find so often the cause of subsequent intestinal obstruction; also the formation of numerous bands of organized lymph, which as often bring a patient to grief in after-years; still worse, it closes all the avenues of escape for the poisonous products of inflammation formed in that great lymph-sac, and in this manner supplies material, the best possible, for keeping up and spreading the inflammation, much more surely than the rubbing together of the parietal and visceral peritoneum will. With salines, on the contrary, the bowels are kept in active peristaltic motion, and this very motion tends to prevent the formation of adhesions and bands; they literally drain the peritoneal cavity of all products of inflammation. This is not merely theoretical, but has been repeatedly observed. A case in the practice of Dr. Penrose showed this most satisfactorily. A large dermoid cyst was ruptured during the tearing away of adhesions, and emptied its contents into the abdominal cavity; in spite of a most careful irrigation a violent peritonitis developed; from the appearance of the first symptom, the drainage tube which had been put in began to increase its discharges until it was almost impossible to keep it dry and clean; as soon as the bowels were induced to act the discharges diminished and quickly ceased altogether. This patient had about twenty-one free watery discharges per rectum. Theoretically the peristaltic action would cause much pain, but practically the increase is slight, and the pain soon is gone altogether. That the peristaltic action increases the inflammation is, I believe, a myth. The saline so depletes the blood-vessels of the peritoneum and intestines that the inflammation soon has little to feed upon, and the bad tendency of friction has but little weight as against the great good obtained by depletion.

There are dangers, of course, from the administration of large doses of salines and

the production of large watery stools, especially to patients who have gone through all the tax on their strength incident to an abdominal section. The patient is much exhausted, and must be fed with strong, concentrated food to supply the place of the nutritive matters lost. One can easily imagine that a case might die from exhaustion, but it will not be necessary to always produce such free purgation as has been done in several instances. Care and judgment must be used in the administration of purgatives, as must be the case with all therapeutics, and a limit put to the number of discharges if they become dangerous in themselves. That a weak, anæmic woman will not bear the drain as well as a better-fed and stronger sister is self-evident. The use of purgatives, it seems to me, is destined to obtain a permanent and valuable place in the after-treatment of abdominal section. As soon as we are able to shake off the inordinate and senseless fear inculcated in our minds by most writers of the day, and the marked results obtained by this treatment are more generally noted, it must come into general use, and we will no longer see purgatives put down as absolutely contra-indicated in peritonitis. To recapitulate, I should suggest that in adominal sections the bowels be moved, as a matter of routine, on the second or third day after operation; that on the first access of pain and soreness a brisk purge be given at once; in case a general peritonitis is developed, the production of large watery stools as soon as possible, both by purgatives and stimulating enemata, is indicated—these to be controlled in accordance with the strength of the patient in each particular case. Of all purgatives for these various purposes, I believe that the salines, as originally suggested by Mr. Tait, are preferable to any other. — *N. Y. Med. Record*, Nov. 5, 1887.

[Calomel, in small doses, (fractions of a grain) frequently repeated, has been employed for the same purpose as salines by Johnson. See *Med. News* Sept. 24, 1887. —ED.]

Hobbs (A. G.) on Nervous Phenomena Observed in a Case of Exposure of the Anterior Column of the Cord, by Syphilitic Ulceration of the Upper Pharynx. — In October last a young man was brought to my office to be treated for "ulcerated sore throat," as his father expressed it.

He had been a cow-boy in Texas for two years, strong and robust, weighing 140 pounds; when he reached me he was thin, pale, and emaciated, weighing only 104 pounds.

He denied ever having had syphilis, nor had he any evidence of this disease other than the ulcer about to be described, and according to his own history there never had been any other symptom of syphilis. A posterior rhinoscopic examination revealed an ugly, sloughing ulcer in the posterior and superior wall of the pharynx, about the size of a silver twenty-five cent piece. By the use of a soft palate retractor a direct view of the greater part of the ulcer could be obtained.

A bent probe discovered necrosed and detached bone at the depth of about half an inch, a piece of which I succeeded in extracting at first sitting. At each succeeding daily visit, for two weeks, small pieces of bone, from the size of a pin-head to a small pea, were either washed out with the cleansing syringe or extracted with the probe or scoop. My index finger would now enter the cavity as far as the first joint, by which means I could discover either detached or jagged, undetached bones.

The treatment had from the beginning been based upon the assumption that it *was* a syphilitic ulcer, notwithstanding his repeated denials of having contracted the disease, and his father's assurances that he had been healthy from infancy and could not therefore have inherited the taint. He began on 40 grains of iodide of potassium three times a day in a menstruum of succus alterans; this dose was afterward doubled. The ulcer was daily cleansed with cotton probes, syringes, and sprays, the latter being applied both directly and through the nose, on account of the discharge being partly expelled through this channel. Listerine was used for its disinfectant and cleansing properties, and nitrate of silver, full strength, was applied at the bottom of the cavity by a cotton probe, after which the cavity was packed with iodo.

About this time, after four or five weeks of daily treatment, the phenomena first occurred.

For a week or ten days he had been complaining of constant pain in the back of his head and neck, which caused him to carry his head to one side and rigidly. During this period—the four or five weeks—he had

been unable to sleep except for a few minutes at a time and in a sitting posture. After the cavity had been thoroughly cleansed at one of the treatments I pressed the nitrate of silver probe to its bottom, when, as suddenly as if he had been shot, one half of the patient's body became paralyzed—his head fell to the right, his right arm dropped to his side, his right leg turned outward, and he would have fallen from the chair if I had not caught him. Without losing consciousness at any time, this hemiplegic condition lasted about thirty seconds, when, as he expressed it, "he felt a tingling in the right half of his body," and in another half minute he slowly raised his right side into position. The next day the same phenomenon was repeated, but on *the opposite side*.

He was now so reduced in weight and strength by the loss of sleep and constant pain that he could not walk to my office. The extreme insomnia lasted about ten days, during which time his attendants thought he did not sleep one hour in twenty-four.

The pupil on the corresponding side of the paralysis was very slightly dilated.

The perspiratory glands were not perceptibly altered in any way on either side of the body during the hemiplegic attacks. But from this time healing began at the bottom of the ulcer, the discharge became less, and examinations with the finger did not discover any more rough bone; he slept better, and did not complain so much of the pain in the back of his neck.

He naturally did not desire that a paralysis should be deliberately produced now, because he was not certain, nor could I with much confidence assure him, that it would only last one minute if repeated.

A week passed on with all his symptoms gradually improving, when I could no longer resist the temptation of making another pressure with the probe. Paralysis of the side pressed upon followed each pressure of the probe, but in a much milder degree than before, ending in the same tingling sensation as described before. As only the spray and powder-blower were used from this time onward in dressing the cavity, no more pressures with the probe were made till healing had well progressed, probably ten days or two weeks after the last test.

To my surprise, when the probe was now pressed into the cavity a condition just

opposite paralysis was exhibited: the arm and leg jerked and jumped similar to a case of chorea. These choreic muscular contractions, unlike the paralysis, lasted only during the pressure of the probe. In repeating the probe pressures at intervals during the next few days the same choreic symptoms were produced, always on the corresponding side of the pressure, but in a less and less degree, requiring a still firmer pressure to produce the effect.

Finally, when the healing process had been thoroughly established and cicatricial tissue had in a measure closed up the cavity, only a "tingling or pricking" sensation followed the probe pressure—a sensation similar to that which followed the hemiplegia in the first instance. After the cicatricial tissue had thoroughly hardened, no manifestation followed the pressure of the probe.

At the present writing, ten months since I first saw the patient, he has entirely recovered, and presents a picture of perfect health, weighing 135 pounds, 37 to 40 pounds more than he weighed in November of last year. He was kept on a lessened dose of iodide of potash and succus alterans until last July.

I cannot state accurately as to the total amount of dead bone taken from the cavity, but I should say that its area would about equal that of a medium-sized almond.

The sequel, it would seem, proved my diagnosis to be correct; since the ulcer had gradually increased in size for six months prior to the beginning of the anti-syphilitic treatment, and though he did not improve at once, as soon as the local treatment succeeded in cleansing the ulcer of necrosed bone healing began, and the more serious symptoms became less.

Some important points may especially be noticed: (1) The necrosis must have occurred in the anterior process of the second cervical vertebra, hence the spinal cord must have been exposed between the second and third vertebræ. (2) The probe pressure always produced its effect on the corresponding side of the body. (3) The pressure that produced the paralysis must have wounded the anterior column by pressing a jagged piece of bone against the cord, and the pressure that produced the convulsions must have only irritated the anterior columns, since it is well known that an irritation applied to the anterior column of the spine produces immediate

convulsions, and a wound produces immediate paralysis.—*St. Louis Med. and Surg. Jour.*, Nov., 1887.

Lautenbach (L. J.). General Conclusions Derived from the Study of the Eyes of One Thousand Insane Patients.—The conclusions expressed in the present paper are derived from the examination and study of more than a thousand cases of insanity, observed either in private practice, or at the Philadelphia and Norristown hospitals. This work has extended over a period of more than four years, and consisted of a thorough eye examination, the ophthalmoscope being employed by the direct method whenever possible, the eye being examined usually with and without dilatation of the pupil; vision for form was taken in all cases; in addition, the ear and pharynx were examined, as it was thought that these examinations might serve as a corroboration to those of the eye. The work was undertaken with the thought that if a sufficient number of patients were examined, it might serve to shed some light upon the pathology of insanity, and it was hoped that, even in a therapeutic aspect, it might prove not unprofitable.

Of course, in the short paper here presented, many points of minor importance evolved during the investigation are omitted, the effort being to indicate the general results obtained, only well-marked characteristics being here presented.

Visions for form, in all conditions of insanity, is practically normal, when we allow for refractive errors, opacities in the refracting media, and unhealthy conditions of the background. Of course, all things being equal, for instance, vision in dementia is not as good as in acute mania, because, as we shall find, in dementia we are dealing with a general degenerative condition, as expressed in the eye by more or less atrophy of the nerve, whereas, in acute mania we usually have present a condition of exaltation, represented by an increased blood-supply in the eye. Then, again, in imbecility we do not expect to obtain the same vision as we would in other cases, as the want of education, and the frequent impossibility thereof, is a factor to be taken into consideration. In conclusion, we may say that vision for form in the insane is the same as in the mentally normal with similar eye conditions.

The visual fields are very often reduced in consequence of the optic nerve degener-

ation so frequently found in cases of insanity; this reduction of the field's area differs not in variety or extent from what we would expect to find in similar nerve degeneration in the same.

The pupils are far more frequently unequal and irregular in outline than in the sane; they are, also, more frequently sluggish, the irides slowly responding; particularly is this the case with the light reflex, the accommodation reflex being more frequently normal. These pupillary variations are more frequent, both in severe acute attacks, as well as in very old chronic cases. In the former we have slowly responding pupils, inclined to dilatation, while in the latter class they are more often unequal and irregular in outline.

Insufficiency of the recti muscles was found to be more frequent in imbeciles and idiots than in the mentally sound, but in the other classes of insane patients this fact was not observed.

Cordeal, scleral, lens, and vitreous troubles are met with in about their ordinary frequency.

Choroidal inflammations are very uncommon, except in cases of general paresis.

Choroidal congestion is more common than among the sane; it is often found in connection with retinal hyperæmia, but not unfrequently it is found alone.

In studying the condition of the optic nerve and retina, it will be found best to take up in a connected manner the various forms of insanity. In fact, after studying the eye conditions among insane patients, one cannot help feeling that there is a very intimate relationship existing between the various forms of insanity; one is led to believe that the three divisions—melancholia, mania, and dementia—are but different stages or phases of the same condition.

We shall find it best to first give the results obtained in cases of acute melancholia, as undoubtedly this is the commencement stage of many, if not all, cases which are found under the classes of melancholia, mania, and dementia.

On examining the eyes of a case of acute melancholia, we find that the fundus almost invariably shows us a condition of retinal hyperæmia, or of congestion. If taken early enough, it is but hyperæmia: the vessels, both arteries and veins, are larger than normal; they are often tortuous, with slight increase in the size of the lymph channels; the general appearance of the

retina is more red than usual, and the nerve is slightly pinkish. If the case goes on into one of acute mania, we have a more marked increase in the blood-supply, we have a condition of congestion: the vessels are larger, the retina becomes darker in color, while the macula lutea loses its brilliancy, inclining to become a dull red. If the case is sufficiently severe, this condition of things continues increasing in severity, and soon we have retinal effusion, with a decidedly pink nerve. If the case becomes better, the congestion lessens, the effusion gradually disappears, and as the case gets well, the eyes gradually assume their normal condition.

Not infrequently we have, early in a case of acute mania, a condition of atrophy presenting itself; or, again, a swelling of the nerve, with obliteration of its edges (a slight papillitis), resulting in atrophy. These cases are not inclined to recover; they are apt to go into a chronic condition, and are almost invariably incurable. It may be that in the case of acute mania the congestion and the effusion remain, becoming no worse, nor yet better. If it continues, we have, sooner or later, an atrophy of the optic nerve resulting. Patients who have had one or more attacks of acute mania, almost invariably present a condition of nerve atrophy in addition to an increased blood-supply. A case of acute mania becoming one of chronic mania, gradually shows more and more atrophy of the nerve, while the congestion gradually subsides, the effusion being absorbed, the vessels becoming less tortuous, and decreasing in calibre. As the case of chronic mania merges into dementia, we have still more marked atrophy, and now we begin to find that the blood-supply is not only not increased, but that it rapidly diminishes, until at length it is less than normal; frequently the vessels in long-standing cases of dementia are very few and very small. When the condition of chronic dementia is fully pronounced, we have a very decided atrophy of the nerve-structure, and a very marked diminution, both in the number and size of the retinal vessels.

There is a distinct and separate class of cases of acute mania which are classed as cases of delusional mania, in which there is almost invariably some heart defect, and we find only a slight degree of hyperæmia of the retina, or else we find the retina perfectly normal. These cases often last

for a very long time; year after year the same mental condition is present; they show no progressive eye change. They are not inclined to get well, nor to pass over into dementia, but die usually in their disturbed mental state, from heart disease.

If a case of acute melancholia is becoming better, we find a gradual diminution of the retinal hyperæmia or congestion, the fundus of the eye clears up, and when the patient has recovered there is usually no vestige left in the eye. Cases of acute melancholia which are but very slowly progressive, in whom year in and year out there is but little change in the mental condition, show but little or no change in the retinal circulation. Usually there is present a hyperæmia which continues on the same plane. The case may continue year after year, and may go on into dementia later on, when we shall begin to notice the atrophic tendency. If, however, there is a tendency to recovery, we find the eye presenting a subsidence of its abnormal condition, the blood-supply is lessened, the vessels are smaller and less tortuous.

There is, however, a series of cases of melancholia which from their onset are very mild in character, and remain so throughout, becoming well in a greater or less length of time. These cases very rarely have any eye change, but, when present, it is of the nature of a very slight retinal hyperæmia, which clears up as the case recovers.

As before indicated, we have in general paresis the majority of the cases of choroidal inflammation. The greater number of cases examined, which have been classed as paralytics, were found to present some syphilitic lesion of the eye.

In imbecility and in idiocy we have blood-vessels whose calibre is greater than normal, the vessels being numerous and tortuous, and the blood-supply is invariably greater than the normal; in addition to this we usually have large optic disks, but they are not of normal color, and seem to present an increased amount of fibrous tissue, showing a poor nerve condition. The macula lutea is usually of a dull red color.

In epilepsy we have present the same conditions, with far less frequency of large optic disks, as in imbecility and idiocy, but it is not so invariable. In addition, we have in epilepsy a more decided tendency to nerve degeneration, and also have an

increase in the size of the perivascular lymph channels, and, in many cases, we have retinal effusions occurring.—*Med. News*, Oct. 22, 1887.

THERAPEUTICS.

Louise (E.) on a New Artificial Alkaloid.—In his Lyons Thesis the author describes a new drug which has been made synthetically, and which bears the chemical name of *oxypopyrlyendiisoamylamine*. It is a colorless oily liquid with a disagreeable odor, slightly soluble in water but readily soluble in alcohol, ether, and fats. Its salts with hydrochloric, nitric, and sulphuric acids are *very* soluble. Its toxic effects in animals would make it fatal in man in a dose of about 3 iii. It has a marked action on the cerebro-spinal system. It produces attacks like those of epilepsy and similar to those caused by absinthe. In small doses it acts as a cardiac tonic and stimulant to the circulation and to the cerebro-spinal centres. Its action upon the heart is somewhat like that of atropine, but it has no effect upon the muscular tissue of the heart or its contained ganglia. It causes a rise in arterial tension and bodily temperature when given in large doses.—*Lyon Mtd.*, Nov. 6, 1887.

Ball on Morphinomania and the Presence of Morphine in the Viscera.—The patient, sixteen years of age, had been a victim to the morphine habit for four years, when she rather suddenly died, after a thirteen days' abstinence from the drug.

On autopsy there were found a large deposit of fat about the heart and slight changes in the myocardium. A chemical examination revealed indubitable traces of morphine in the nervous centres, the spleen, and most of all in the liver.

For these and other reasons the author concludes that cardiac tonics, particularly spartein, are indicated in the treatment of such cases, and that sudden withdrawal of the drug is dangerous.—*L'Union Mtd.*, Oct. 20, 1887.

Fell (G. E.) on Forced Respiration in Opium Poisoning.—The patient whom the writer first treated in this way was an adult male who had taken about twenty grains of morphine to relieve the sleeplessness of alcoholism. All ordinary remedies had been tried, and the case was

considered hopeless. At last it was decided to perform tracheotomy and use the apparatus employed to keep up artificial respiration during vivisections in dogs.

The mode of operating and its results are better given in Dr. Fell's own words :

"The tracheal tube was quickly cleaned with a bi-chloride solution, and, with instruments illy adapted to the purpose, the operation was begun at nine o'clock A.M.

"The hemorrhage, which was considerable, was soon overcome with hæmostatic forceps and ligation. Before incising the trachea, it was reduced to a minimum. The greatest difficulty was experienced in passing a ligature about the trachea to prevent the air from passing up the throat. After this was accomplished we were ready to begin the respirations. The color of the blood passing from the incision was of a dark coffee-color, indicating an extremely venous condition.

"Having been deeply occupied with the operation, I had not noticed the condition of the patient further than to state that no respiratory effort had been made for some time, and the dark-blue tinge to the face had materially increased.

"We began the *forced respirations*, and, as some interesting physiological changes ensued, it may be well to note them carefully. The lungs were inflated ; not the slightest expiratory effort was made, indicating paralysis of not only the muscles of respiration, but the loss of elasticity in the lung tissue. Now forced expiration was effected in the best manner by pressure on the thorax.

"The effect of the forced respirations was observed much sooner *on the heart* than *on the lungs*. The change from the venous to a more arterial state of the blood was the one first noticed ; it was also observed that the pulse at the wrist had become stronger and quite regular ; this was some time before any attempts at respiration on the part of the patient were noticed. The forced respirations, in fact, were kept up some twenty to thirty minutes before any attempts at breathing were noted, and, before others were observed, a long interval elapsed. In the meantime, the face had begun to assume a more natural appearance, the dark venous color had given way to the natural ruddy appearance of health, and then came two or three quick, hurried movements of the chest, the *first attempts* at natural breathing. The lungs subsided,

and without both *forced* inspirations and expirations, some time after this, our patient would have quickly succumbed. Sensibility was quickly returning, as evidenced by movements of the muscles of the eye when pressed by the finger.

"The next feature of interest was a movement of the limbs, quickly followed by one of the arms, and, shortly following this, the eyes opened, staring wildly. We soon found that our patient could hear and understand. Water was offered and eagerly swallowed; inclinations or slight nods of the head would indicate when he desired more or had had enough. All this time, we were performing the respiratory acts for him, and to me the various effects produced by *withholding* or supplying an *excess* of air were extremely interesting, and enhanced from the fact that it was a human being we were operating upon.

"After about two hours' work, the natural respirations became longer and longer, until they appeared almost normal. The opening in the side of the valve (one eighth by one half inch, or one and four tenths by three tenths mm.), which permitted the natural respirations, was not large enough to supply the lungs with their full requisite of air, so that natural breathing could only be carried on for a short time before dyspnoea would ensue. This was evidenced on the part of the patient by gasps and uneasy movements. When this occurred, the natural were supplemented by the *forced respirations*, with the effect of always quieting and easing the patient. When the *forced respirations* were kept up for a short time, and the blood became surcharged with oxygen, it would be some time before attempts to breathe would be made; this was frequently observed. Advantage was taken of this, and the blood surcharged with oxygen, when the change from the cumbersome tracheal tube of the respiratory apparatus was made for an ordinary tracheotomy tube, when the patient was allowed to breathe for himself.

"No mention has been made of the difficulty encountered in the operation after the patient revived and began to move uneasily about; these movements loosened the tube in the trachea and started hemorrhage, and as at this time the patient was depending upon the forced respiration for his life, the result was made uncertain. This was the most serious time in the operation. At this time, and before the tracheal

tube was first inserted, considerable blood passed into the lungs; it was subsequently coughed out at the valve of the apparatus.

"At twelve o'clock, mid-day, after the forced respirations had been under way *two and one half hours*, an ordinary tracheotomy tube, as stated, was substituted for the tube of the apparatus, and the patient allowed to breathe for himself.

"The essential conditions required in an instrument adapted to the performance of forced respiration are as follows:

"First—An air-forcing apparatus—ordinary bellows.

"Second—A tracheal tube, which may be left in the trachea for twenty-four hours or more if required, and fitted with annular corrugations or a rubber tampon, as in the rubber tampon of Semon, to permit it to be securely held or tied in the trachea.

"Third—A valve so arranged that the surgeon can completely control the passage of the air from the bellows to the lungs, and, when free, will permit the air to pass readily out and into the lungs; or, in other words, so that the surgeon need only manipulate the valve during the inspirations.

"Fourth—To prevent the movements of the patient from disarranging the tube in the trachea, a flexible rubber tube connection should be made between the tracheal tube and the air-supply valve; and to insure greater convenience in manipulation, a flexible connection should be provided between the air-supply valve and the bellows-apparatus.

"Fifth—The tracheotomy tube should be supplied with a movable piece, to which the rubber tubing can readily be attached or detached, to allow the respirations to be renewed when required.

"An important addition to this apparatus, which could easily be added and not complicate the operation, would be a vessel of tin, or copper, arranged similar to a Woolf bottle, in which the air passing through water, heated with a spirit lamp, and medicated, if desired, with a suitable stimulant, could be used in cold weather. The value and simplicity of such an apparatus, supplied with a thermometer to gauge the temperature of the water or air, is at once apparent; the depression produced by forcing *cold* air into the lungs could be obviated and consequent injury to the lung tissue would be reduced to a minimum."—*Buffalo Med. and Surg. Jour.*, Nov., 1887.

Duboué and Lardier on the Use of Tannin in the Treatment of Acute Inflammations of Serous and Mucous Membranes, Particularly in Meningitis.—Duboué has for twenty years found tannin efficient in meningitis, peritonitis, pericarditis, pneumonia, and ovarian cysts.

Lardier, in a desperate case of tubercular meningitis, after getting no help from ordinary remedies, ordered tannin in fifteen-grain doses every three hours. After the first dose the delirium became lessened. After the second dose the child slept and the respiration became calm. On waking, the child appeared intelligent and the pulse and temperature were nearly normal. The child continued to improve, and was declared undoubtedly convalescent in five days.—*Le Praticien*, Oct. 31, 1887.

Shoemaker (J. V.) on Geranium Maculatum.—If the craze for therapeutical novelties could be diverted from the jungles of India and the laboratories of the manufacturing chemist to the fields and forests of the United States, suffering humanity would be the gainer. Many of the most highly-lauded, marvellous synthetical products and wonderful drugs precipitated upon the profession during the past few years are not only useless but positively injurious, while scarcely 2 per cent. of the remainder possess any practical value.

Geranium maculatum, to which I desire to redirect your attention to-day, is not a new remedy imported over thousands of miles of land and sea at prodigious expense, neither is it the patented compound of forty stills, recommended as a sure cure for all diseases by forty medical theorists who do not know the difference between the pulse in health and disease, but it is one of the most valuable and yet the least known of American indigenous remedies. More than sixty years ago Dr. Barton, in briefly reviewing its medicinal properties, declared it to be certainly entitled to the attention of every American physician. Yet notwithstanding the commendation of Dr. Barton and other distinguished observers, *geranium maculatum* has been almost entirely discarded. Indeed, so seldom is it prescribed that druggists in many places do not keep it in stock. When I began to investigate its merits five years ago, not one of the eight druggists to whom I sent for it had any on hand; and

I was finally compelled to send to a wholesale house for the quantity needed.

Geranium maculatum contains tannic and gallic acids, gum, starch, sugar, coloring matter, and various resin and oleo-resins, which have not yet been studied. Its value depends in large part upon the tannic and gallic acid present, but its resins, oleo-resins, and other constituents enhance its usefulness, and render it more potent in many affections than any preparation of tannic or gallic acid alone or combined. The portion of the plant used in medicine is the rhizome, or the root stripped of its bark. The dose of the powdered root ranges from 10 to 40 grains. As it is soluble in water or alcohol, it may also be administered in the form of the tincture or the fluid extract. The dose of the former preparation varies from $\frac{1}{4}$ to 2 drachms, and that of the latter from 10 $\mathfrak{m}$ to 3 iss. The fluid extract is the most eligible and effective preparation, as it contains all the virtues of its plant. When combined with an equal quantity of simple syrup and diluted with a small amount of water it is not unpalatable, and will not be rejected by the most fastidious patient.

Therapeutic Action.—There are few remedies which possess a wider range of usefulness than *geranium maculatum*, and which are so devoid of harmful properties. In all forms of hemorrhage, whether internal or external, it is without a superior. Hemoptysis can usually be promptly arrested by drachm doses of the fluid extract given hourly until the attack subsides. Relapses may be prevented by continuing the same dose at longer intervals for three or four days. Hæmatemesis may be effectually controlled in the same manner after ergot, matico, sulphuric acid, iron, ice, and other styptics have failed. In hemorrhage from the kidneys and the intestinal canal better results can be obtained from the administration of smaller doses, gtt. xx. four times daily, for an extended period. Epistaxis may be speedily checked by plugging the nostrils with cotton dipped in a solution composed of one part of the fluid extract of *geranium* and three parts of water, or by syringing the nasal passage with the same solution. Hemorrhage resulting from the extraction of a tooth is occasionally obstinate in character, persisting for days, defying the cautery and other methods, enfeebling the patient and alarming the family, but it can invariably be promptly ar-

rested by filling the socket with a piece of cotton saturated with the undiluted extract of geranium maculatum, and applying firm pressure for a few minutes. Metrorrhagia can be most effectually abated by the internal administration of geranium combined with vaginal injections of the same remedy. In fewer cases it may be necessary to tampon the vagina with cotton soaked in a diluted solution of geranium, or to inject the uterine canal with the same solution. This latter procedure is the most effective method of arresting uterine hemorrhage, but it must be resorted to with caution.

Geranium is also of virtue in purpura, scurvy, hæmitidrosis, and the hemorrhagic diathesis. It is a most serviceable remedy in colliquative and chronic diarrhœa, infantile diarrhœa, and the diarrhœa of typhoid fever. It may be given with marked benefit in the later stages of cholera infantum, cholera morbus, and chronic dysentery. In the latter class of affections, rectal injections of the remedy appear to be most efficacious, as by this means the medicament is conveyed directly to the diseased portion of the mucous membrane. This is also an effective method of eradicating ascarides.

Geranium is of especial value in phthisis, restraining the diarrhœa, preventing hemorrhage, moderating the fever and night sweats, lessening the cough, and promoting the appetite.

In chronic bronchitis and bronchorrhœa marked improvement may be obtained from the administration of

R	Tinct. nucis vomicæ	3 j.
	Tinct. sanguinarie	3 j.
	Ext. geranii fl.	$\frac{3}{4}$ jss.
	Syr. simp.	$\frac{3}{4}$ jss.

℥

SIG.—Teaspoonful in water every four hours.

Chronic gastric catarrh, and the various stomach disorders due to indulgence in alcoholic liquors, can be most speedily remedied by a restricted diet, reformation of habits, and the administration of 3 ss of geranium four times a day.

Cases of anæmia and chlorosis in which iron, arsenic, strychnine, phosphoric acid, and quinine have not been of any benefit, frequently improve at once upon drachm doses of geranium before meals. Amenorrhœa and other disorders of menstruation dependent upon poverty of the blood, often disappear spontaneously during a course of geranium.

Aphonia due to nervousness, mild cases of hysteria, and alcohol trembling, are all benefitted by full doses of geranium frequently repeated. I believe that it will also be found of service in the treatment of chorea.

Diluted with three parts of water, it forms an elegant and effective gargle in relaxation of the uvula and fauces, chronic pharyngeal catarrh. Applied in the same strength with a post-nasal syringe or douche it is without a superior in naso-pharyngeal catarrh. When combined with an equal quantity of water it forms an excellent mouth wash in aphthæ, scurvy, mercurial stomatitis, and idiopathic softening of the gums. In leucorrhœa and chronic gonorrhœa, it may be given internally, and also used as an injection in the proportion of 1 part of the fluid extract to 10 parts of water. The injections should not be used more than once every second or third day. Purulent cervicitis, fissures of the cervix, and catarrh of the body of the uterus and relaxation of the vaginal walls can be cured by the application of the fluid extract of geranium, either through the medium of an injection or by the ordinary cotton tampon and application.

The pain and irritation attendant upon fissure of the anus can be removed at once by touching the fissure with the undiluted extract, and a permanent cure effected by continuing the applications two or three times daily for a few days. Prolapsus ani will usually yield rapidly and not recur if the pure fluid extract be brushed daily over the protruding mucous membrane, and a 25-per-cent. solution be injected into the rectum every second day. Ulceration of the rectum and anus may be rapidly arrested by the same means. The repeated application of the fluid extract will relieve the irritation and lessen the size of hemorrhoidal tumors, and not unfrequently occasion them to shrivel up and disappear. A 10-per-cent. solution of geranium is a useful application in chronic conjunctivitis, granular lids, and corneal ulceration. The undiluted extract is without a superior in the treatment of fissured nipples. It relieves the pain at once, and forms a protective covering over the painful cracks, beneath which the healing process continues undisturbed. Unlike lead, and the commonly displayed agents, it is harmless to the infant, and need not be washed off before nursing.

Geranium is an excellent remedy in various forms of disease of the skin characterized by excessive secretion. In hyperidrosis and bromidrosis, no more effective plan of treatment can be suggested than bathing the affected parts three or four times a day with a 30-per-cent. solution of the fluid extract. The flow of perspiration is lessened and the fetor removed. Vesicular and purulent eczema, impetigo, and pemphigus are benefited by the following lotion:

℞	Extract. belladonnæ fl.	. . .	3 j.
	Extract. geranii fl.	. . .	3 j.
	Aque	. . .	3 ij.
			℥

SIG.—Apply night and morning.

The same application will be found both prophylactic and curative in intertrigo, and in eczema and herpes of the genital regions, in persons having a peculiarly delicate skin. It is also efficacious in preventing the development and hastening repair of bedsores, and promoting the healing of old indolent ulcers. Geranium is the best styptic in the materia medica, but it must not be expected to control the flow of blood from an incised artery. It will check venous or capillary oozing, restrain the bleeding of lacerated wounds, and arrest the hemorrhage following small incised wounds, or various minor operations, more effectually than Monsel's solution, alum, or any of the agents ordinarily employed. It must, however, be applied in the proper manner. To let a few drops fall on the bleeding point will not be sufficient. A small piece of cotton should be soaked in the pure fluid extract and held firmly against the wounded or bleeding surface for a few minutes. A piece of sticking plaster or an ordinary bandage may then be applied. When this method is adopted stitches need not be inserted unless the wound is deep and the edges gaping. Hemorrhage does not recur, and the healing process begins at once and continues without interruption.

Sloughing and unhealthy sores rapidly assume a healthy appearance when continually bathed with geranium. Vaginal and intra-uterine injections are rarely necessary after delivery, but when the fetor of the lochia or other symptoms demand their employment, a decoction of geranium or 10-per-cent. solution of the fluid extract will be as efficacious as solutions of carbolic acid or mercuric bichloride, and far more safe and agreeable to the patient.

Pruritus ani and vulvæ are due more frequently than is supposed to minute fissures of the skin of these regions, or to a relaxed and œdematous condition of the mucous membrane, and consequently can often be promptly relieved by the application of a strong solution of geranium.

Finally, the fluid extract of geranium, owing to the large percentage of tannic acid which it contains, is a convenient and effective antidote in cases of poisoning by iodine, mercury, silver, copper, antimony, digitalis, conium, gelsemium, tobacco, physostigma, belladonna, and aconite. —*Four. Am. Med. Ass'n*, Oct. 29, 1887.

Comstock (A.) on Sierra Salvia, or Rocky Mountain Sage.—The maladies incident to the region where the plant is found are such as would be natural to expect from the sudden changes from hot to cold, due to conditions so clearly defined and illustrated in the report of Prof. Langley upon high altitudes. A clear sky is overcast with dense clouds, and an evening shower follows which may depress the thermometer from 90° to 50° F. in an hour's time, and hence one exposed and overtaken while riding will suffer from an abrupt and almost complete suppression of the offices of the skin. As a result the kidneys may suffer, or the lungs, or what is here termed the "mountain fever," which uncomplicated involves the upper spine, when the cord is congested in the region of the cervical ganglia, extending perhaps through the entire tract. The chill announcing it is a signal for an active system of relief or a long and tedious convalescence. Whilst quinine was formerly used and seems to be indicated, the dry skin and high temperature with cerebral congestion is best allayed by an infusion of the mountain sage. Other animals than man appreciate it, and in the coldest portions of the year antelope, deer, and even grouse are fond of securing its tonic effect, and will consume of it so freely that late in winter their tissues are flavored with it.

From personal experiment and observation in many climates, from the range to coast, for several years I find it the most effective single ally in cases of periodic fever, rheumatic or neuralgic affections, the exanthemata, diphtheria, and kidney troubles of the type where a diaphoretic or diuretic is required, of any named in the entire list of materia medica products. If taken hot it at once affects the capillaries, as would

be expected from the office of the stomach in digestion, and a free diaphoresis follows. When used cold, it acts upon the kidney in from three to five hours, and often in one half this time. It should be taken freely diluted, and quite unlike the former teachings in that respect. In wineglassful portions, and as often as three times per hour till full effects are induced, and with no prescribed amount, is now my custom. Not more than three fourths to one half a drachm of the bloom to a pint of boiling water, and steeped as cautiously as the most delicate cup of tea, or till the fibres settle to the bottom of the china bowl (for no metal should be used), when it is ready for use, and may be taken not as a medicine, but as freely as the patient be inclined, always after retiring, to get the best results for action on the skin and to quiet nervous irritation. I am also fond of using the infusion as the basis of a lemonade, if acid is indicated, sweetened, etc., to taste. For a tonic and taken cold, it may be taken in less quantity, say a wineglassful, as the Germans use the hot or cold water for gastric irrigation. About one half a fluid-drachm of the fluid extract will be tolerated and act best when diluted with a full pint of hot water and allowed to cool, being meanwhile covered so that none shall volatilize by way of steam. If, however, the infusion from the herb be preferred, do not spoil it by making it too strong, and always prepare fresh every day. For the cases indicated it is not improbable that, when patiently tested, it will become as much a staple as the cinchona preparations of South America, the cloves of South Africa, or the rheum of Asiatic India and China. *Therapeutic Gaz.*, Oct. 15, 1887.

Hyvernaud (J.) on the Treatment of Cancroids by the Chlorate of Potassium.—The author, in his thesis, including ten unpublished cases, has collected sixty-three cases of cancroids treated by the chlorate of potash alone. Of these cases thirty-two recovered, fifteen improved, and in sixteen the treatment was unsuccessful. The cases which heal most readily are those where the skin, particularly that of the face, is attacked, while those cases where the mucous membrane is diseased do very badly. It is in chronic cases and where ulceration has commenced that the best results are obtained.

The internal administration of the drug appears almost useless. The drug is ap-

plied in a warm saturated solution or in very fine powder directly on the surface of the sore, the crusts having been removed, two applications daily being made.

No immediate effect is noticed from the use of the solution, but a general tendency to cicatrization is noticed. The powdered drug has a mild caustic action. Healing is generally uninterrupted but slow, weeks and sometimes months being consumed in a cure.—*Thèse de Paris in Ann. de Dermat. et de Syph.*, Oct. 25, 1887.

Hull (G. S.) on the So-Called Antiseptic Action of Calomel When Given in Large Doses.—In cases of dysentery most prompt results in relieving tormina and changing the character of the stools were manifested. It acts as a cholagogue, producing a free flow of bile, sweeping out the contents of the bowel, and as a mercurial it exerts an antiseptic action. In cholera its usefulness in large doses has been advocated by some and denied by others.

The first effect of the calomel in epidemic dysentery is to empty the bile-ducts and get a large flow of bile, and relieve the congestion of the liver and intestinal vessels. The second effect is due to the solution of the mercurial in the bile, as pointed out by Headland, and this probably acts as an antiseptic in the bowels. The object is not simply to purge the patient, but to obtain a copious bilious discharge from the action on the liver. Where the tongue was most coated he got the best results. He believed that patients are killed by the use of opium and astringents.—*Cincin. Lancet-Clinic*, Oct. 29, 1887.

Squires (G. W.) on Mercury with Chalk in the Treatment of Tape-Worm.—The writer has sometimes found mercury with chalk a most effective tæniacide, and cites the following case in illustration: "G. W., aged thirty-one, a blacksmith by trade, had complained of an indescribable feeling in his stomach, bowels, and all through him, as he termed it, for three or four years. There was a wild look in his eyes, and a peculiar appearance of the skin which attracted people's attention so they would ask what ailed him. His appetite was fastidious; at times he would eat voraciously, then again eat nothing. He became greatly emaciated, and vomiting grew so incessant that he was unable to retain any food. The vomiting had continued about six weeks when I first saw

him. He had been treated by several physicians, but said he was getting worse instead of better. I gave him three powders of hydrargyrum cum creta, with directions to take one, morning, night, and morning, with a dose of castor oil after the last powder. He came back in three days surprised, smiling, and happy, saying he had passed a tape-worm thirty feet long. He was no longer troubled with vomiting, ate heartily, improved rapidly, and has felt like a new man ever since the worm was expelled."—*N. Y. Med. Record*, Oct. 29, 1887.

Brobst (J. C.) on Egyptian Tamarind for Hemorrhoids.—Very recently my attention has been attracted to the Egyptian tamarind flower, a blossom that may be considered a most excellent specific for bleeding hemorrhoids or piles. In my practice I have had the most extraordinary results from its positive curative powers, and especially has this been so in cases deemed incurable and given up by other physicians. Prior to using it, I was in the habit of employing injections of turpentine, perchloride of iron, ointments of nutgall, oxide of zinc, rosemary, acetate of lead, and numerous other astringents; and while these may all give temporary relief, the actual or net result is irritating rather than soothing, as most certainly are the effects of the tamarind flower. I have noticed, after giving my patients three or four wine-glassfuls of the decoction, that they were instantly relieved of the persistent itching and burning sensation, while the excrement seemed to be materially altered by it. I have also tried "tamarind" in nervous, debilitated women, with like good results, especially when their sickness has been complicated with costiveness and loss of appetite. In these cases tonic properties were plainly discernible, and tamarind flower may in my judgment be well considered a "tonic laxative."

Dr. W. H. Howell speaks of tamarind flower in decoction as one of the best laxative nervines. The flower also makes an excellent face-wash, and for the removal of freckles and pimples it cannot be excelled. —*Med. and Surg. Reporter*, Nov. 12, 1887.

Vidal on a Purgative for Lead-Poisoning.—Vidal uses sulphur as a purgative in cases of saturnism, as it acts also by eliminating the poison. He employs sulphur and honey in equal parts, and commences with a coffeespoonful and continues that dose or increases it according

to circumstances.—*Four. de Méd. et de Chir. Prat.*, Oct., 1887.

Hulme (L.) on a Case of Acute Ergotism.—A woman aged forty-eight, married twenty-eight years, two children, youngest fourteen years old, has suffered for several years from the presence of fibroid tumors of the uterus, causing menorrhagia. One of these tumors being pedunculated, was removed two years ago by the ecraseur. One submucous nodule of about the size of a hickory-nut was allowed to remain. The patient recovered from the operation without any bad symptoms. The menorrhagia was lessened for several months, but again increased. She had had hot vaginal injections in connection with the remedies usual in such cases, with little benefit from any. On the second day of the menstrual period, the flow being excessive and proving more uncontrollable than usual, at 10 A.M. I administered one small teaspoonful of Squibb's fluid extract of ergot, and left the patient quite comfortable. On returning, less than forty minutes afterward, I found her in a half fainting condition. The countenance was swollen, pallid, and denoted great anxiety; the respiration was shallow and frequent; the extremities were swollen, and the hands increased about one fourth in size. The abdomen was also much enlarged. Pulse frequent, weak, and irregular. The pupils were equally dilated, and vision indistinct. She complained of great dizziness and nausea. The flow continued as before, and no signs of uterine contraction were evident; she had no pain.

I administered whiskey f3j, and aromatic spirits of ammonia, gtt. x, every half hour, until 2 P.M. she felt stronger and her pulse was normal in frequency (although very full and quick). The pupils were still widely dilated, and vertigo prevented the patient from leaving the bed. The swelling of the face and extremities continued to increase until 7 P.M. In twenty-four hours the symptoms began to decrease and gradually subsided, the dizziness and indistinct vision being the last to disappear and lasting several days.

One of the most interesting points in this case was the absence of all evidence of uterine contraction, unless the nausea can be referred to this cause, as it is by Dr. Keating in a case mentioned in Ringer's "Therapeutics," when the nausea attendant upon the administration of ergot in a case

of fibroid tumors was much increased by the introduction of the finger into the os; and also in a case which came under my own observation, where the introduction and dilatation of a sea-tangle tent caused little pain, but great and constant nausea and vomiting until the dilatation was complete, when all symptoms ceased entirely.

As to what to ascribe the deleterious effects of the drug in this case, I am at a loss to determine. The preparation was freshly procured from a reliable druggist, and has not caused any disagreeable symptoms in the patients to whom I have administered it since. The patient had frequently taken ergot on former occasions and in as large a dose.—*Medical News*, Nov. 5, 1887.

Dorland (W. A. N.) on Ustilago Maydis—A Study of the Drug with Reference to Its Employment as an Oxytotic.—Whether or not a disastrous effect would be produced by the administration of the drug prior to the commencement of the second stage of labor cannot be stated. As yet, that question has not been decided. From the study of the physiological action of *ustilago*, we should think all danger of the irregular contractions of its compeer, the ergot of rye, would be precluded, and that if there were any possibilities of the exigencies of the case demanding its use, it might be employed with impunity during the first stage of labor. At present, however, we shall consider the first indication for its use to be the failure of pains, with *complete dilatation of the os uteri*.

In no case has the drug been employed by me until the pains of labor had either become so weak that they were inefficient to accomplish the expulsion of the foetus, or until they were entirely suspended. We then consider the second indication for its use the *inefficiency or entire suspension of the parturient pain*.

After the *ustilago* had been taken, it may also be noticed that in no case was there the slightest tendency toward a post-partum hemorrhage. In each case, after the expulsion of the placenta, the uterus remained in a state of firm contraction. While during three months' trial the great majority of the remaining cases, in which the customary ergot had been employed, showed no tendency whatever toward this alarming accident, however, in two instances was there such an occurrence demanding prompt at-

tention. The third indication, then, for the employment of *ustilago* we shall consider to be *a condition of uterine inertia threatening or producing post-partum hemorrhage*.

The preparation of *ustilago* employed in all reported cases, as well as in our own, was a good fluid extract. The dose of this varies from one half to two drachms, one drachm being a fair average. This may be repeated at intervals as required. Should it be necessary, it may be used hypodermatically in doses of from five to fifteen minims.

Dr. Frank H. Potter, in a paper on the "Proper Use of Ergot in Obstetrical Practice," closes his article with a series of ten conclusions. In these he states that when administered during labor the action of ergot is uncertain, producing irregular contractions, rigidity of the os, with interference of the placental circulation, or too rapid expulsions of the foetus, jeopardizing the maternal tissues. He also asserts that the life of the child is endangered through absorption of the oil of ergot, and that indirectly the drug may prove a cause of puerperal septicæmia by preventing the removal of every portion of the placenta and membranes. His last conclusion is as follows: "The proper use of ergot in obstetrical practice is limited to those cases in which, after the expulsion of the placenta, the uterus refuses to contract, or, having once contracted, shows a tendency to secondary relaxation. Even in these cases reliance should not be placed upon it alone, but its action should be supplemented by the other means used to provoke uterine contraction."

When compared to the formidable array of objections against ergot, the employment of *ustilago* seems much to be preferred. It does not produce irregular contractions with all the consequent complications and sequelæ; containing but two and a half per cent. of fixed oil, while ergot contains from twenty-five per cent. to twenty-eight per cent., the dangers of absorption are reduced to a minimum; and, finally, as it can be procured at a cost of fifty per cent. less than that of ergot, it seems to be on a fair highway toward the supplanting of the latter in obstetrical practice, should the results of the investigations thus far be confirmed by subsequent researches.—*Med. News*, Nov. 5, 1887.

Onimus on Medicinal Oxidation by Means of a Platinum Sponge as a Therapeutic Agent.—The apparatus consists of a piece of platinum sponge kept incandescent by the vapors of alcohol, ether, or an essence. The hot platinum oxidizes the substances and develops ozone and ethereal products. By using alcoholic or ethereal tinctures their effects can be produced by leaving the apparatus in action for a short time in the room. It acts best in diseases affecting the air tract.

It quickly destroys odors dependent upon decomposition, and very greatly retards the putrefaction of unstable fluids and solids.—*L'Union Méd.*, Nov. 3, 1887.

Myndman (J. G.) on Menthol in Tubercular Laryngitis.—From his observation of five cases, two well advanced, the author corroborates the conclusion of Rosenberg with his eighty cases. Within a week there was a marked improvement in subjective symptoms, diminished dysphagia, increased hopefulness, and improved nutrition. The ulcers became covered with flesh, healthy granulations, and in from two to ten weeks became perfectly cicatrized. The thickened and infiltrated mucous membrane did not subside, until the application of lactic acid, which is far more painful, but at the same time more rapid in its effects. The cumulative action of menthol is noticed. The effect of succeeding applications is more prolonged, until one application daily is quite sufficient. Alcoholic solutions (5 to 20 per cent.) are more manageable than the oily, and have not been found to cause pain. Dr. Thorner spoke enthusiastically in favor of lactic acid in the treatment of tubercular ulcers. In two cases ulcers healed within six weeks under applications of lactic acid in 20 per cent. to 40 per cent. solution.

C. H. K.

Mygind (Holger)—A New Method of Inhaling Nitrate of Silver in Different Diseases of the Air Passages.—The effect upon the mucous membranes of a vapor of nitrate of silver was accidentally discovered in 1874 by a Norwegian photographer. He had suffered for a long time from a severe chronic bronchitis. He happened to be standing over a boiling solution of silver and nitric acid, and for some time he inhaled the rising vapors. After the first irritation had passed away, he felt a pleasant warm sensation in the chest, and from that time he had no more

cough. Bidekap undertook to investigate the matter and tried the inhalations in a great number and variety of diseases of the air passages, using less acid vapors. The patients were allowed to remain in a room, where the vapors were produced for one or two hours, every two or four days. His results were favorable, especially in cases of chronic nasal and pharyngeal catarrh, in chronic laryngitis and tracheitis, without complications, and in chronic bronchitis, even associated with emphysema. Eleven years later these results were corroborated by Dr. J. C. Holm, of Norway, and more recently they have been confirmed by Blomberg, of Christiania, and by Storch, of Copenhagen. In order to avoid formation of acid vapors, Holm found it advantageous to slowly heat pure nitrate of silver with ammonia nitrate. Blomberg used an apparatus similar to the usual spray-producers, but differing from them in that the atomized watery solution was highly heated before leaving the tube, so that only the dry fumes of the salt were inhaled.

This method seems to be only a slight modification of the ordinary spray inhalation. It differs from the latter, however, in the fact that whereas therapeutic agents suspended in watery vapor, as spray inhalations, may reach the bronchi, the same suspended in the air in minute and light particles, as in the method under consideration, find their way to the terminal bronchi without special respiratory effort. Although it might seem possible that the effective agents are the gases developed during the process, yet the fact that many observers by different methods have reached similar favorable results, would tend to prove that the actual remedy is the atomized nitrate of silver. This method is not free from danger. If the inhalations are too prolonged, or the patients inhale cold air directly after the treatment, there is risk of irritating the lungs, or even producing acute pneumonia. Again, there is a possibility of producing chronic silver poisoning. It is, therefore, wise not to allow patients to use the inhalations themselves, and not to continue treatment too long. Finally, the method appears to have no advantage over the present system of application to the upper air passages. The following plan is recommended as simple and practical. In the middle of a small room, on a low table is placed a small Berlin crucible or evaporating pan, containing one

part of nitrate of silver and three parts of ammonia nitrate, which is slowly heated by a spirit lamp. The face need not be protected, but linen or white clothing should be covered. The time of each inhalation should not exceed thirty or forty-five minutes, and treatment should not extend over too long a period.—*Four. of Laryngology and Rhinol.*, Sept., 1887. C. H. K.

Harris (J. O.) On the Production and Uses of Moist Heat in the Treatment of Disease, or an Efficient Means of Producing Speedy Diaphoresis.—Get a tinner to make a round tin box, eight inches in diameter and four inches deep; have him attach an open handle or socket three inches long and one and a quarter inches in diameter on one side near the top; attach a hinged cover perforated with one-half- or five-eighth-inch holes; bend at right angles two pieces of tin doubled, half inch in diameter, across the cover; then put a wooden handle fifteen inches long in a socket, and your apparatus is ready. Being called to a case presenting all the symptoms of a congestive or pernicious chill, he sends a messenger for a quantity of unslacked lime, and while waiting his return gives the patient ten grains of Dover's powder, and has some woollen sheets or blankets brought and his patient placed between them. As soon as the lime is at hand he partly fills the tin box with it, pours over it a pint of hot water, closes down the cover, places the box between the patient's legs, and tucks the blankets down close around the patient. In ten minutes he says the chill has disappeared and the patient is bathed in profuse perspiration. In half an hour he allows the moist flannel sheets to be removed and replaced by dry warmed cotton ones, and directs the necessary antiperiodic remedies for preventing a recurrence of the chill. Dr. Harris further illustrates the efficiency of his method by the two following cases:

Miss F. F. D. had been out on a damp, chilly day while "unwell," with thin shoes, and her monthly flow was suddenly stopped, followed by terrible pains in the pelvis and loins. The use of the tin sweat-box, with lime, in the manner previously described, speedily induced profuse general perspiration with relief of pain, and in a few hours the menstrual flow had returned.

The other was N. C., a merchant with an unusually severe attack of acute rheuma-

tism, caused by a thorough wetting while out hunting and overtaken by a cold rain. Being called the next evening, and finding the patient suffering intensely, he gave him at once a powder composed of pulv. opii grs. iss, nit. pot. grs. x, and pulv. zingib. grs. ij, and went out for his sweat-box and lime. Returning he applied it between the legs of his patient, under woollen coverings, in the same manner as previously described. At first the patient was disposed to ridicule the remedy, but soon admitted that it was getting warm, a little later asked to have some of the heat "let out," and finally declared he was being "cooked alive." "The result of the operation was that in less than an hour my patient was free from pain, and by noon the next day was walking around the store."—*Four. Am. Med. Ass'n*, Nov. 12, 1887.

Rushmore (J. D.) on the Use of Veratrum Viride in King's County, New York, with Especial Reference to Its Control of Puerperal Convulsions.

—The following conclusions seem to be fairly deducible from somewhat limited experience; that veratrum viride is employed by the profession in Kings County to a very limited extent; that, except in the treatment of puerperal convulsions, it is used in the method commonly recommended by the text-books; that, in the management of puerperal eclampsia, it has been administered in large and sometimes heroic doses with no poisonous effects in most cases; and where alarming symptoms have developed after its use, they have easily been relieved by usual remedies; that in health a large dose may produce both very alarming symptoms and death; that a tolerance of the drug is produced by vascular tension, common to many diseases; that it is a safe, certain, and manageable vascular sedative; that, in order to control the convulsions of the puerperal state, it must be given in doses sufficiently large to bring and keep the pulse down to about sixty beats per minute, and that thus far it has given a mortality of thirty-one per cent.—*Gaillara's Med. Four.*, Nov., 1887.

Cecil (J. G.) on the Elimination of Medicines by the Mammary Glands.

—The author concludes:

1. That the practice of medication of the child through its nurse's milk promises very little, and is altogether too uncertain to be relied on.

2. That great caution should be observed

in the administration of narcotics to nursing women.

3. That greater care than usual is demanded in the exhibition of drugs during the first few days after parturition, and when for any reason the milk is poor and thin in quality.—*Amer. Pract. and News*, Oct. 15, 1887.

Hubbard (R.) on Strychnia in Sea-Sickness.¹—Some seven or eight years ago, while on a trip to Savannah, six of the lady passengers were severely attacked with seasickness when only about twelve hours out. Fully concurring with Dr. Skinner's theory of the pathology of the disease, I directed each patient to take one fortieth of a grain of sulphate of strychnia every fourth hour. Five were well after the fourth dose, and remained so to the end of the voyage. The sixth was a delicate young lady in the second stage of phthisis pulmonalis, and was so prostrated that actually I feared death by asthenia. She was panic-stricken, and importuned so earnestly for immediate relief that I substituted for the strychnia twenty-drop doses of chloroform in water. This only aggravated the symptoms, so I returned to the strychnia, and after a few additional doses she was well.

I have treated many victims of seasickness, and I am prepared to declare emphatically that strychnia, pushed if necessary to the point of toleration, has accomplished more in my hands than any one or all other remedies. I have had no experience with atropia, but should anticipate from its centrifugal influence on the circulation that it would prove a good adjuvant to the strychnia. Cocaine, one sixth to one quarter of a grain, has proved an excellent palliative in my hands, but its influence, as also that of the bromides, has been transitory.

I have found no difficulty in my patients retaining the strychnia pellets or tablets, and therefore have not used it hypodermically.—*Boston Med. and Surg. Jour.*, Oct. 27, 1887.

Palm (T. A.) on Nitrite of Amyl in Cholera.—During an epidemic of cholera in Japan in 1879, it occurred to me to make trial of the inhalation of nitrite of amyl in the treatment of the collapse of cholera. I found that cholera patients in a state of collapse could inhale it very freely before an effect was produced. My plan was to hold a bottle of it under the

nostrils, directing the patient to sniff it up freely, and to repeat this frequently. Under its influence a small, thready pulse increased in volume, and where the pulse at the wrist was imperceptible it became perceptible. I have reason to think that in some cases it was the means of saving life.—*Br. Med. Jour.*, Nov. 5, 1887.

Suckling (C.)—Arsenic in Chronic Degenerative Diseases of the Nervous System.—A gentleman, aged forty-five, who has led a most arduous life, and has performed an excessive amount of mental work, having been secretary to various societies in addition to his own professional work, consulted me in July last. He had been ill for eighteen months with headache and sleeplessness, and his memory for recent events was much impaired, his wife telling me that he could not carry on a conversation, as he would stop in the middle of a sentence, forgetting what he had said, and forgetting also the subject of the conversation. He had had several attacks, moreover, of transient weakness in the right arm and leg, and had suffered from pains in the legs. I found that the pupils responded to light but were unequal; that the speech was slurred, and that the facial muscles were tremulous in action. The knee-jerk was quite abolished on the right, but present, though diminished, on the left. There was, moreover, considerable optic atrophy, the discs being gray and the vessels small, sight being greatly impaired.

I concluded that he was suffering most probably from general paralytic dementia in an early stage, and that degenerative changes were supervening in the spinal cord of the nature of tabes dorsalis. I prescribed arsenic, $\frac{1}{10}$ grain, in a pill, to be taken thrice a day. In August I again saw him, and he expressed himself as feeling better, but I noticed little change in his condition. In September he told me that his legs were better, and that his knees seldom gave way under him as they had often done before, and his wife told me that his memory was much better, and that he never complained of headache or drowsiness. I again saw him on October 19th, when he was decidedly improving; the pupils were still unequal, but the tremor of the facial muscles had disappeared. The most remarkable change, however, was disclosed by the fact that the knee-jerk on the right side had reappeared. He had gained six

¹ See MEDICAL ANALECTIC, Nov., 1887, p. 510.

pounds in weight, and his sight had slightly improved, for he could now tell the time from his watch, which he had not been able to do for twelve months.

This is the only case of recovery of a lost knee-jerk in general paralytic dementia in tabes that I have yet met with, and, considering the usual inefficacy of drugs in the treatment of these diseases, the action of arsenic in the above case seems worthy of record.—*Br. Med. Jour.*, Oct. 29, 1887.

PATHOLOGY.

Persy (P.) on the Cutaneous Manifestations of Uræmia.—In his Paris thesis (1887) the author describes the various dermatoses which have been observed in uræmics. He notes the frequency of pruritus and prurigo among patients with arterio-sclerosis and interstitial nephritis. He reports a case of general papular erythema occurring in a case of typhoid fever of a renal type; also he speaks of cases of ecthyma, furuncles, and purpura, of which he has observed examples in the course of an interstitial nephritis.

Bullous eruptions have been seldom seen in Bright subjects, but Persy has seen two such cases, in both of which the uræmic symptoms were of a nervous variety. He attributes pemphigoid eruptions to nervous changes, and says they are similar to pemphigoid eruptions seen in hysteria, general paralysis, and after lesions of peripheral nerves.

As to the other eruptions occurring in uræmia, some depend on the uræmia itself—*i. e.*, deficient elimination by the urine and alteration of the skin and cutaneous nerves by materials not eliminated by the urine; others (as purpura), on the hydræmia and hypo-albuminosis and the co-existing changes in the walls of the small vessels; others still (as ecthyma, furuncles) are due to the fact that, in uræmics with albuminuria, the resistance of the tissues is reduced to its minimum, thus allowing the development of micro-organisms introduced by the slightest solution of continuity of the skin. Finally, in such cases it must not be forgotten that sometimes the morbid processes are coincidences, and, again, that the eruption may be medicamentous.—*Ann. de Dermat. et de Syph.*, Oct. 25, 1887.

Matas (R.) on Acute Circumscribed Œdema.—It was in the month of May,

1886, when I was called to attend an Italian woman, aged thirty-six, who complained to me of the symptoms which constitute the basis of this narrative. Outside of malarial fevers and a few accidental complications of childbirth, she rarely suffered with disease. For the last two months and over she had been afflicted with a peculiar disfigurement of the face.

This "disfigurement," she explained to me, was a large swelling that took place daily between 8 and 11 A.M., which appeared in the upper lip and caused it to rise to the level of her nostrils, obstructing the nares, and projecting over two and three inches beyond the surface of the teeth. The swelling came on gradually, but continued to increase for some hours until it reached a maximum about 12 M. or 1 P.M., when it gradually subsided, so that by 3, 4, or 5 in the evening it had totally disappeared, leaving no trace behind it.

The swelling was perfectly painless, and to use her expression was "doughy" to the feel, and only bothered her by its ungainliness.

The periodicity of the affection and its long duration, above all, were curious. Sometimes it appeared in the evening and disappeared late at night.

I examined her mouth, but I failed to see any lesion that could reasonably account for the swelling of the upper lip, though some of the molars were carious. The urine was carefully examined for albumen, casts, and sugar, and the specific gravity carefully taken, and I found it normal in every respect. There was no anæmia, no evidence of any dyscrasia; nothing, in short, that an attentive clinical survey could seize as an efficient factor in the causation of the trouble.

I saw the patient myself during the œdematous period. Her lips, and especially the upper one, are thin normally and of a darkish red hue, but now the upper one projected from her face like a proboscis. The lip had indeed assumed elephantine proportions and impressed on the features a curious, grotesque appearance. The enlarged labium hung over the lower like an overhanging tumor, of a pale, waxy, leaden hue, especially on its mucous portion. On touching the mass it felt, as the patient said, "doughy," pitting on pressure, and feeling cold and almost clammy to the touch. The cheeks did not appear to participate in the infiltration and neither did

the eyelids, the swelling appearing to blend gradually with the remainder of the face on a level with the naso-labial furrow.

I again examined the mouth to reassure myself, and took the temperature under the tongue, but the whole examination gave only negative results.

The periodicity of the affection suggested malaria, and the malaria quinine. I therefore ordered quinine sulphate, twenty grains, in capsules, to be administered in the evening, and ten more early in the morning, at least three hours before the usual appearance of œdema.

Two days after, at 2 P.M., I was much surprised to see the patient herself at my office, and what was most satisfactory was that she bore no evidence on her face of the annoying trouble, even to the presence of the heretofore hidrophilic labium. I have learned that she has been completely free from any return of the trouble since the time when I prescribed for her.

Riehl reports two patients afflicted with acute circumscribed œdema of the skin. This affection, which has been described by Quincke, consists in the sudden appearance, and without any appreciable cause, of an œdematous tumefaction, which, in the course of two or three hours, becomes very pronounced, and disappears completely at the end of twenty-four or thirty-six hours. This tumefaction is localized ordinarily in the dorsal aspect of the hand and in the face, in the eyelids, about the mouth, the lips, the cheeks, and sometimes in the pharynx and larynx, where it is liable to produce suffocation. In one of Riehl's cases the affection has persisted for three years in the zygomatic region; in the other, thirteen years in various parts of the body. Subsequently, Riehl presented further details in regard to these two patients. As to the last instance, that of the patient who became ill with the disease in 1874, he tells us that he is a man aged forty-one years, who had always been healthy prior to 1874, when, shortly after the death of his wife, he was suddenly seized with œdema in the left eyelid, which, appearing suddenly at night, disappeared as quickly the next morning. From this time on and at various intervals he presented œdematous localizations in various regions of the face. At present, the œdematous seizures are repeated every eight or ten days, which, outside of the inconvenience resulting from the altered appearance, cause no trouble.

In the other case he referred to a man thirty-three years of age, who was attacked three years before, eight days after his wedding, by an acute œdema of the left cheek. Since that time he has these limited œdemas every fifteen days.

In these two cases the general condition of the patient is all that could be desired. The urine is normal, and there exist no hereditary antecedents. But this is not always the course of this affection. In a case reported by Quincke the appearance of the œdema was always associated with a general *malaise*, somnolence, vomiting, etc.

Strübing mentions three cases which were characterized by intense gastric disturbance, and vomiting as often as twenty or thirty times daily, constipation, psychical disturbances, etc., even when the œdematous areas were insignificant in size. Hereditary influences appear to play a part in this affection, and *apropos* of this Strübing relates the case of an old man of seventy who was affected with acute circumscribed œdema, whose son suffered also with the paternal affection. Analogous examples have been reported by Quincke, Falcone, etc.

The etiology of the disease is still obscure. The influence of traumatisms has been appealed to to explain the condition, and, in fact, Quincke succeeded in producing an acute circumscribed œdema in a predisposed subject, by inflicting slight blows on the face, etc., but this mechanical causation must entirely play a secondary rôle, acting purely as an exciting agent in already predisposed subjects. Moral disturbances have been regarded, and perhaps with some foundation, as important predisposing factors.

As to the actual phenomenon itself, *i. e.*, the œdema, it is accounted for by Quincke, for instance, as an angio-neurosis. Strübing attributes it to an exaggerated excitability of the vaso-dilator nerves. Riehl opines that the difficulty lies much more in the central nervous mechanism and in its peripheral dependencies, and in support of this opinion he appeals to the migratory or metastatic character of these œdemas, and their association with nervous disturbances of a peripheral character and vomiting.—*New Orleans Med. and Surg. Jour.*, Oct., 1887.

Hughes (A. W.) on Transient Localized Œdema of the Lip.—A case to which I have given the above designation

came under my notice a few days ago, when I was called to see a patient whose lower lip had become enormously swollen during the night, the swelling being confined to one side, extending only to the middle line of the lip, where the line of demarcation between the swollen and healthy tissues was very definite. The patient told me that some years ago a similar swelling occurred, which also appeared during the night, and, like the present one, disappeared gradually during the early part of the following day, having caused no inconvenience beyond a slight difficulty in articulation and mastication, which was not due to any pain, but simply to the large size of the lip. I may mention that a lymphatic gland, which I considered abnormally large, could be felt on the same side of the face, on the surface of the jaw near the anterior margin of the masseter muscle, but this, the patient informed me, was always of the same size.

I recommended no treatment, for, as I anticipated, the swelling disappeared in the course of a few hours, but I was naturally expected to explain the condition. At first, upon noticing what I considered an enlarged gland in the course of the lymph stream from the part, I thought the swelling was due to lymphangiectasia, from some blocking of the lymph-vessels, or some interference with the flow of lymph through the gland. But I now consider the following a more feasible explanation: that during sleep the facial vein was compressed at the point where it crosses the lower jaw, thus stopping the flow of blood through it. This compression would not interfere greatly with the venous circulation in the upper part of the face, but the flow of blood out of the veins of the lower lip would be greatly impeded, as these veins open into the facial below the communication above mentioned, which communication is therefore unable to relieve the inferior labial veins which are now engorged.

This engorgement would lead to extravasation of lymph and swelling, unaccompanied by any inflammatory symptoms, and this swelling is transitory, because when the compression is removed the circulation returns to its normal condition, and the extravasated lymph is re-absorbed.—*Br. Med. Four.*, Sept. 24, 1887.

Carver on a Supernumerary Tooth.

—The patient was a child, aged six and a half years, with a tooth growing from the right lower eyelid. The patient, when

born, had a small excrescence on the lower lid of the right eye. This increased in size until he was about four and a half years old, when there appeared on the outer side a small white spot, which was found to be hard, and gradually the crown of a tooth (canine) was protruded until the whole tooth obtruded. In this condition it remained until removed. The fang of the tooth was somewhat bulbous. The number of deciduous teeth was perfect, and he had cut the upper and lower middle incisor teeth.—*Br. Med. Four.*, Oct. 15, 1887.

Despres on Enormous Distention of the Abdomen Due to Paralysis of the Abdominal Muscles.—The patient entered the hospital with the diagnosis of ovarian cyst. It was found that in dorsal decubitus the protuberance disappeared, and on examination she was found to have no tumor. The abdominal walls were not fatty, and on examination it was found that they had lost their electro-contraction; in other words, the abdominal muscles were paralyzed. The woman had had two easy parturitions, and it was after the first that the relaxation had commenced. The girth at the umbilicus was fifty-eight inches.—*Le Courier Méd.*, Oct. 29, 1887.

Hirst (B. C.) on Acute Pneumonia in Utero.—The author asserts that pneumonia during intra-uterine life is rare, but it has been observed. Dr. Strachan, of Australia, *Br. Med. Four.*, 1886, II., p. 860, has reported a case, and Dr. Geyl, of Germany, *Arch. f. Gynäk.*, Bd. XV., S. 384, has collected three others. Geyl's explanation is undoubtedly the correct one for this occurrence. If the foetal blood is not properly aerated, the respiratory centre in the brain is stimulated to action by the excess of carbonic acid gas in the blood, and the foetus makes inspiratory efforts, drawing into its lungs amniotic fluid, containing in these cases, possibly, meconium, and a catarrhal pneumonia is the result, ending usually in the death of the foetus, either in utero or shortly after birth. These cases are to be distinguished from those in which the foetus draws into its lungs amniotic fluid, mucus, and blood during labor. The author's case was an infant which died twenty-two hours after birth, having been cyanosed from the first. The mother had had a large lumbar abscess for the past year, and when she came under observation in the Philadelphia Hospital, in the sixth month of pregnancy, exhibited all

the signs of general septicæmia. She gave birth to her child at the seventh month of gestation. The post-mortem examination of the infant showed no other cause for death except the pneumonia involving both lungs, which must have arisen in utero, as the labor was easy and rapid, and there was no reason to believe that the child made inspiratory efforts during its expulsion. The microscope confirms the diagnosis. They showed well-marked catarrhal pneumonia.—*Am. Four. Obstetrics*, etc., Nov., 1887.

Howard (R. P.) on Hepatic Cirrhosis in Children.—Most of the established causes of the disease in adults obtain also in children, more especially the use of alcohol, present in 15.8 per cent. of the whole number syphilis, chiefly hereditary syphilis, present in 11 per cent.; tuberculous disease of other organs than the liver, in 11 per cent.; also, but much less frequently than these, venous congestion of the liver, peritonitis, and a general tendency to connective-tissue formation in the system.

Syphilis occasionally tends to a diffuse interstitial hepatitis or cirrhosis, by first inducing an adhesive inflammation of the portal vein.

General arterio-capillary fibrosis is not proved by these cases to be the usual, and probably not even a frequent, cause of hepatic cirrhosis in childhood.

More than half of the cases of hepatic cirrhosis in children do not appear to be produced by the above-mentioned well-established causes of that affection.

There is some evidence that cirrhosis of the liver may be very exceptionally induced by the acute infectious diseases—cholera, typhoid fever, measles, scarlatina,—but that proof of this is wanting.

The habitual use of a stimulating diet, or the absorption of the products of faulty digestion, are probably fruitful sources of hepatic cirrhosis in children.

It is in harmony with what is known of the causes of hepatic cirrhosis to believe that the bodies known as ptomaines may be capable of exciting a cirrhotic condition, and that investigation of this subject deserves attention.

The period of childhood most liable to cirrhosis of the liver is from the ninth to the fifteenth year inclusive, but that it may be congenital and may occur at any age after birth.

It is twice as frequent in male children as in female.

Its symptoms are essentially the same in childhood as adult life.

It is frequently accompanied by pyrexia.

Ascites or icterus, and frequently both together, are of common occurrence in the atrophic and the hypertrophic forms.

The group of symptoms which have been referred to cholæmia or to cholestæmia or to acholia, and even sometimes to uræmia, frequently ushers in the fatal issue of hepatic cirrhosis in children.—*Am. Four. Med. Sci.*, Oct., 1887.

Greene (G.) on Calcification of a Portion of the Penile Urethra.—Some months ago I was consulted by a man, aged sixty, who had all the symptoms, both subjective and objective, of stone.

During one of his visits, he drew my attention to a small nodule on the under surface of the penis, which on examination I found to be a hard, gritty substance, measuring nearly a quarter of an inch in its long axis, and apparently filling up the urethra almost completely, as the smallest-sized catheter could not be insinuated beyond the point of induration. The patient states that since he noticed this kernel (as he terms it), the pain has become more constant, and is always referred to the neck of the bladder; the stream of water is not interrupted suddenly as before, but is much narrower, and passes with greater difficulty and pain. The last time I saw him it had increased to the extent of half an inch, and felt harder, the anterior portion being thinner than the posterior, and seemed to have assumed a spout-like profile, the sides of which were adapted to the floor and lateral portions of the urethra.

The foregoing is, I believe, judging from the symptoms and course of the disease, a case of either (1) a hypertrophied horn of a mulberry calculus, which projects into the urethra, but remains attached to its nucleus in the bladder; or else (2) a centre of calcification has originated *per se* in the urethra itself, probably from a detached portion of calculus getting lodged in a neighboring lacuna on its journey through the vesical outlet.—*Br. Med. Four.*, Oct. 8, 1887.

Shakespeare (E. O.) on the Infectious Nature of Traumatic Tetanus.—*Conclusions drawn from the author's personal researches:*

1st. Traumatic tetanus of the horse and

mule is, at least sometimes, if not always, an infectious disease, transmissible to other animals, and therefore possibly also to man; and during the progress of this disease a virus is elaborated and multiplied, which is capable of producing the same infectious disease in some other animals when placed beneath the dura mater of the cerebrum.

2d. This virus is contained in the medulla and spinal marrow of the animal suffering with the disease. It is, like the virus of hydrophobia, capable of being strengthened in virulency by inoculation sub dura cerebri from rabbit to rabbit, and, like the virus of hydrophobia, is capable of attenuation by exposure for a sufficient time to the action of dry air at a temperature of summer-heat, and, still again like the rabic virus, its effects are far more intense when the virus is inserted beneath the dura mater cerebri than when injected beneath the skin or between the muscles of the back.

3d. The author reserves his conclusion concerning a prophylactic effect of inoculation of the attenuated virus until the completion of experiments which are at present in progress.

Conclusions drawn from the author's experiments when correlated with those of Nicolayer, Corle and Ratone, Rosenbach, Ferrari, Flügge, Hochsinger, and others:

Traumatic tetanus of the lower animals and of men, at least sometimes, possibly always, is a specific infectious disease due to the action of a specific infectious virus which exists in the tissues at the seat of infection, in the blood, and in the central cerebro-spinal nervous system.

In view of experimental evidence which we possess at present, and of many unsailable observations of numerous surgeons and veterinarians, there seems to be ample warrant for the admission that not infrequently tetanus in man is acquired directly and indirectly from some of the domestic animals by which he is surrounded, and notably from the horse.—*Medical Times*, Oct. 15, 1887.

Billings (F. S.) on the Germ of Texas Fever.—I wish to announce to the medical profession and scientific laboratories the first discovery of the germ of that devastating American cattle plague, the Texas, or Southern cattle, fever.

In order to be justified in making such an announcement, an investigator must fulfil the following conditions:

1. Find a given germ invariably in the organs of organisms having a specific disease.

2. Isolate and cultivate said organism from these tissues.

3. Prove that said germ has pathogenic action upon animals used for experimentation.

4. Produce the same disease in healthy animals of the same species in which the disease occurs under natural circumstances.

These conditions I have fulfilled in every particular.

First, by finding the germ in the blood, gall, urine, liver, spleen, and kidneys.

Second, in making pure cultures from the blood and liver.

Third, by killing ground squirrels with inoculations of pure cultures in about forty-eight hours.

Fourth, by inducing the same disease in cattle and proving the presence of the germ by microscopical examination and cultivation.

This germ belongs to that class of septic germs represented by our swine-plague, the "wild seuche" and "schwino seuche" of Germany, and rabbit septicaemia. It is a bacterium. It colors at its poles, and has a clear or non-coloring middle piece to its body. Like the H. C. germ, it has motility in hanging drop cultures and also in the blood serum from the original blood of a diseased animal. It cannot be distinguished from the H. C. germ under the microscope, or in its growth on agar-agar, but differentiates itself very sharply by its growth on potatoes, having a delicate straw color, while the H. C. germ has a muddy, coffee color—"boarding-house-coffee color," a friend suggests. In gelatin I have not yet tested it on account of the obstacles of the prevailing temperature.

That it is the first discovery of this germ may be seen by reference to the literature.

In the Agricultural Reports of the Department at Washington is recorded all that has been done on this subject.

In those of 1880-81 and 1884, Ditmers reports and illustrates a "bacillus," and a gigantic one at that. It is not this germ.

In the Report of 1883, Salmon claims to have discovered a "diplococcus," which has "a figure-8 form" and is "without any power of movement."

Neither give any experimental evidence of a positive character to support their conclusions. The same will, however, fol-

low this announcement in course of time.—*Am. Lancet*, Oct., 1887.

Biggs (H. M.) on the Diagnostic Value of the Cholera Spirillum.—Two days after the arrival of the "Alesia," October 16th, a boy six years of age was removed from the ship suffering with an affection resembling cholera morbus. The characteristic symptoms of Asiatic cholera were not all present in this case, and in view of the insufficient evidence of the occurrence of any cases of this disease among the passengers since the date of sailing, considerable doubt was entertained as to the nature of the disease. On the 18th the boy died. It was a matter of the gravest importance that an absolute decision should be arrived at as to the nature of the disease in this case. The autopsy did not reveal any thing that assisted in deciding the question. Dr. Armstrong, of the Marine Hospital, Stapleton, Staten Island, was present at the autopsy, and inoculated gelatin cultivation-tubes from the contents of the ileum and the colon, respectively. On the following day transfers were made to other tubes by Dr. Kinyoun, of the hospital, from the growth that had taken place in the tubes first inoculated, and the specimens of this second series were brought to the writer by the health officer on the following day, October 20th, with the request that they be examined. On microscopical examination, bacteria were found that in their morphological characteristics corresponded closely to those of the cholera spirillum. The writer then requested that two days be allowed for the preparation, growth, and examination of plate cultivations, as the morphological appearances are not characteristic enough to serve as a basis for diagnosis. Cultivations were furnished to Dr. Prudden, and independent examinations were made by him, Dr. Kinyoun, Dr. Week, and the writer, with exactly the same result, *i. e.*, the discovery and the isolation of an organism corresponding in all its morphological and biological characteristics to the so-called cholera comma bacillus. The case was, therefore, without hesitation declared to be Asiatic cholera, and was so reported to Dr. Smith. The occurrence of other cases subsequently added a confirmation, which, however, was not necessary for the establishment of the diagnosis.

The morphological and biological characteristics of the cholera spirillum, taken

together, distinguish it sharply from all other known forms of micro-organisms, and its presence in the dejecta is absolutely pathognomonic of Asiatic cholera. I have given the history of this case somewhat in detail because it was one where an immediate absolute diagnosis was of the greatest importance, and where it could only be arrived at by the biological examination. The alternative was to await the appearance of other cases, and thus incur the danger of sacrificing many lives. The latter method was formerly the only one at our command. This is also, I believe, the first case in this country where a diagnosis of Asiatic cholera has been based upon biological examinations. It has seemed to Dr. Prudden and myself that too much emphasis could not be placed upon the importance and positive value of this kind of examination for the diagnosis of doubtful cases of this disease.—*N. Y. Med. Jour.*, Nov. 12, 1887.

Freire (D.) on the Vaccine of Yellow Fever.—The vaccine is prepared as follows: The blood of a patient, dead or about to die of yellow fever, is injected into the veins of a guinea-pig or a rabbit. A second animal of the same species is then inoculated with the blood of the first, and so on for six or seven animals. With the blood of the last cultures are made, which are transplanted at least four times; then I commence inoculations upon man, not, however, without having first ascertained, by experiments on animals, that the inoculations will not produce grave results. We thus obtain a tenth or twelfth generation from the primitive microbe, the virulence being notably diminished. The attenuation is caused by the new conditions with which the microbe is surrounded in passing through the organism of the guinea-pig, and its after cultivation in sterilized test-tubes containing beef broth or gelatin.

The following is the method of procedure: The culture fluid is taken from the flask with every precaution against foreign germs, and preserved in small tubes containing from one to two drachms, these being sterilized by heat and stopped by emery. A few drops of the liquid are turned into a clean capsule, taken up by a Pravaz syringe, and then there is thrown under the skin a quantity varying from two to fifteen minims, according to the age of the individual. The disturbances which result from the vaccination are like the

prodromes of yellow fever. They are manifested by intra-orbital headache, rigors, general lassitude, with heaviness of the limbs, backache, febrile action (99.5° , 100.5° , 102.5° F.), slight epigastric pain, and sometimes nausea, or even vomiting, all lasting not longer than two or three days without the use of remedies. There is no local cause for these phenomena, for there only appears around the puncture a slight reddish areola, which quickly disappears.

If we recapitulate the vaccinations by the hypodermatic method during 1885 and 1886, we obtain the following result :

First vaccinations in 1886	3,473
Deaths of vaccinated persons	7
Second vaccinations in 1885	3,051
Deaths of vaccinated persons	1
Total vaccinations	6,524
Total deaths of vaccinated persons	8
Mortality of vaccinated persons	1 per cent.
Mortality in yellow-fever cases of non-vaccinated persons, according to official reports for the years 1885 and 1886	1,667

Let us now arrange this so as to include the statistics of 1884, when we employed the endermic method ; we have :

Vaccinated	6,942
Deaths of vaccinated persons	15
Which gives us hardly two per cent. of mortality of vaccinated persons.	
Deaths of the non-vaccinated	2,317

—*Med. News*, Sept. 17, 1887.

Dalton (H. C.) on Malignant Emphysema.—The patient miscarried about January 15th, and again about March 15th.

She entered the hospital March 15th. She had a sister who had fits. Her constitution and general health had been poor. She had pneumonia five years ago, followed by cerebro-spinal meningitis ; she had antepartum hemorrhage $4\frac{1}{2}$ years ago. She stated that present sickness commenced about a month ago with general muscular lassitude ; menstruation came on and lasted one day ; this was followed by intense headache ; bowels constipated. She took laxatives, and bowels have been loose most of the time since.

About a week ago she vomited several times ; vomited matter was of a greenish color. Had not vomited since, until last night. She has no appetite ; tongue coated ; liver slightly enlarged and tender. Patient was jaundiced. The whole right pectoral

region and arm were swollen and crepitated on palpation. Patient had considerable pain in right breast and arm ; respirations were hurried and deep. Passages last night and this morning were loose and tarry. Patient was menstruating. She stated that she had hemorrhage from lungs several times two or three years ago ; had night sweats and cough ; lost in weight and had œdema of feet.

Many small punctures were made in right breast to allow the escape of the accumulated gas, which had an odor of sulphuretted hydrogen gas ; respirations became more rapid and difficult ; lips and fingertips cyanosed ; extremities cold ; emphysema extended up to the neck and almost over the entire chest. She died at 6:15 P.M., March 18th. The autopsy was made 17 hours after death.

Body of a well-developed woman. Chest, right shoulder, and neck are puffy and discolored, color ranging from a bluish green to a dark brawny red. Rigor mortis present. Crepitation of subcutaneous tissues obtainable in throat, thorax, abdomen, and upper extremities. General, but slight, jaundice. Superior longitudinal sinus contained light-colored clot. Spleen normal in size ; intensely congested ; no blood flowed from cut surface ; tissue soft, friable, crepitated, but did not float. Kidneys larger than usual, flabby, much congested ; capsules stripped off easily, leaving a granular indented appearance of their surfaces. *Stellæ Verhuyii* prominent. Both kidneys crepitated on pressure and floated in water. Liver of normal size ; crepitated, but did not float in water. Crepitation noticed in walls of stomach, which was congested at its cardiac end, externally and internally ; contained a considerable quantity of greenish fluid. Uterus 10 cent. (4 in.) in length, contained dark-colored material of the consistence of jelly. The organ emitted a fetid odor ; its tissue was firm, but crepitated and floated in water. Heart tissue was soft and friable, crepitated and floated. Serous linings of aorta showed evidence of recent inflammation. Heart cavities contained clots of reddish brown color, which crepitated and floated in water.

Before the thoracic cavity was opened, air was forced into the nose ; the mouth being closed, it went directly to the stomach. The anterior wall of the trachea was then perforated, and through this the lungs were inflated fully, but no air escaped from

¹ This is the case referred to in *MEDICAL ANALECTIC*, 1887, p. 377.

thoracic walls. This was done to determine whether or not the emphysematous condition proceeded from the lungs. The right pleura was also inflated by a hole through its external wall and was found to be intact. The cellular tissues beneath the integument of both arms, right forearm, throat, and abdomen were infiltrated, the air having the odor of sulphuretted hydrogen. Its color here was dark with a reddish tinge, seeming to be in an early stage of gangrene. No point of origin for the emphysematous condition could be discovered.

The internal mammary, subclavian and its branches, axillary, and brachial arteries were found to be clear, likewise the accompanying veins, with the exception of the *venæ comites brachialis*, which contained a soft, dark-colored clot, beginning at a point 13 cent. (5 in.) above the elbow-joint, and extending to the shoulder-joint, having a length of 10 cent. (4 in.). The vessels of the left upper extremities were empty.

It will be noticed that there was an emphysematous condition of many of the external organs. The case is very unique and an extremely rare one. I think the whole trouble due to the miscarriages.

Dr. Bremer examined almost all the organs and found that the whole organism was fairly swarming with bacteria. It must, however, be taken into consideration that the post-mortem took place 17 hours after death. It has been demonstrated that the bacillus of malignant emphysema will multiply after death; this is not the case with other bacterial diseases. So a great many of the micro-organisms seen in this case are of post-mortem growth. However, it was demonstrated that this material was extremely malignant; two mice and one rabbit inoculated with it died in 18 hours, and their bodies were found to be swarming with these identical organisms.—*Four. Am. Med. Ass'n*, Sept. 24, 1887.

Lawson (G. L. L.). A Suggestion Why Pneumonia and Phthisis Select Different Localities in the Lung.—The vertical distance between apex and base in the adult is about twelve inches, more or less. The external atmosphere has equal access to both apex and base.

The sp. gr. of blood is 1055, therefore the difference between blood pressure from gravity on the capillaries of the base and those of the apex is about half a pound on each square inch of surface.

The difference in the counteracting pres-

sure of the atmosphere is practically nil. The greater blood pressure on the base being counteracted by 1st—greater tone of the sympathetic and pneumogastric nerves, leading ultimately to—2d—an increase in the strength of the parenchyma. Therefore the greater blood pressure in the base is practically counteracted by increased nerve tension. From this it follows that if a susceptible person be exposed to a chill or cold prolonged enough to incite pneumonia, the nervous tone is lost, the pulmonary branches of the sympathetic relax equally; the capillaries of the base, having to sustain a greater blood pressure than those of the apex, are less able to withstand the increased rush of blood, consequently they dilate; their tone being lost and their resistance overcome they are unable to react, and then we have congestion, perhaps proceeding to inflammation. As the lower part becomes congested and the passage of blood through it becomes impeded, the capillaries on a higher level are successively congested. Thus it spreads upwards until the inflammation runs its course, or there is sufficient tone in the vaso-constrictors to prevent its further progress. The right base is more often attacked than the left. Fagge says "the right lung is more often the seat of inflammation than the left, the proportion being about five to three." Now the right apex extends higher than the left. The right lung as a whole is higher than the left, but at the back part of the base they are practically on the same level, therefore there is greater blood pressure on the right base, or the pressure being equal, the right base being larger than the left also accounts for it. Again, in hypostatic pneumonia supervening on other complaints, the most dependent part of the lung is attacked, because there is loss of tone in the vaso-constrictors and the blood pressure is greatest in the back, which, in this case, is the lowest part of the chest. Here I have spoken of pneumonia as an inflammation of the lungs, and have not discussed the origin of the inflammation, but simply the cause of its selecting a special site.

In phthisis the apex is primarily affected. It is not from any inability of this part of the lung to expand and receive its proper supply of air, otherwise we would find other corners and edges of the lung equally subject to phthisis.

Tanner says the left apex is usually affected. The right apex is higher than the left, and the right should be oftener attacked; but here the beneficial effects of exercise are plainly demonstrated. The right area being exercised more than the left, and both lungs being equally subject, this continual exercise will more than fully counteract any slight predisposition there might otherwise be in the right apex.

No doubt in some men the vesicles in the apices do collapse, but not from inability of the air to fill them. The blood pressure here is less than in the base, the circulation flags; as a result of this the vesicles collapse, there is a diminution in the nerve force, blood pressure, and also in nourishment. The capillary walls not being so braced up, as it were, collapse, and are less able to withstand the attack of any debilitating complaint—*Australasian Med. Gaz.*, Sept., 1887.

Thomas (W. R.) on the Pathology of Bright's Disease.—According to Dr. Thomas Bright's disease is invariably preceded, often for years, by the presence of large quantities of some material in excess, such as phosphates, urates, oxalates, lead, alcohol, in the urine; that these constituents are more frequently to be found about mid-day than at any other time; that after a time a small quantity of albumen will invariably be found accompanying it, and ultimately more evident signs of renal disease evince themselves; that the presence of this constituent constantly in the blood, present there for excretion, gives rise to the hyperplasia of fibrous tissue and subsequent changes—*Brit. Med. Four.*, Oct. 15, 1887.

Turner (F. C.) on a Lipomatous Tumor of the Spinal Cord.—The growth formed an oval swelling in the continuity of the cord of the size of a large olive. It was composed almost wholly of fat, one half of the transverse section consisting wholly of simple adipose tissue, the other half of the atrophic remnant of the cord infiltrated with fatty tissue. Microscopical examination of sections of the growth showed that the cord at this part was reduced to a network of nucleated fibrous tissue enclosing areas of fat. In the broader track of the fibrous growth were the remains of the nervous tissue more or less degenerated. Dr. Turner considered that the lipomatous growth had originated in the pia mater, and had en-

sheathed the cord, and had subsequently invaded the medullary tissue. It was regarded as a lipomatous fibro-sarcoma.—*Brit. Med. Four.*, Nov. 5, 1887.

Abbe (R.) on Osteoplaques of the Thigh.—The patient, sixty years of age, had two large bony plates above the left knee, occupying the site of the lower halves of the vastus externus and vastus internus muscles. The internal one measured six and a half by four inches, and had an estimated thickness of an inch. They were freely movable. They represented the amalgamation of numerous bony nodules in the muscle, observed as long as forty years ago. They had been watched for three years, and had changed but little. The flexing of the knee was partially restricted, and at long intervals the joint became painful and a little swollen when overtaxed.—*N. Y. Med. Four.*, Nov. 12, 1887.

MEDICINE.

Walker (J.) on the Value of Written Directions in the Treatment of Chronic and Prolonged Illness.—A careful study of cases of chronic and prolonged illness led me to believe that patients, though starting out at first with enthusiasm to follow the doctor's advice,—perhaps the new doctor's advice,—after a while grew tired of being limited to this or that thing, or of following out the doctor's directions. And so it comes that chronic cases, or the parents of children who had been long ailing, are ever ready to try new doctors or new remedies. The chronic case is apparently just beginning to be relieved after the attending physician has repeatedly thought and studied about it, when all of a sudden the case whisks off to another doctor, who, perchance, having the previous physician's experience to guide him, takes a different line of treatment, or even follows out the same line and effects a cure, or more commonly the previous doctor's experience is his experience, and the patient, without any warning it may be, hurries to a third doctor, and so on and on until patients grow discouraged because they get little or no relief, and the doctors become discouraged also. Some of these patients, it may be intelligent and well-meaning persons, so lose their faith in the regular medical fraternity that not only do

they at times revile them, but are very apt to consult quacks and irregular practitioners of various kinds. How, then, can prolonged or chronic cases of illness be induced to follow out any well-defined plan of treatment under one physician for a sufficient length of time to test the efficacy of the plan? I answer by treating the case on "business principles." Having once decided that such a plan would yield the best results for both patient and physician, I awaited the chronic case. It came in the person of a young lady who had chronically enlarged glands of the neck and behind the ears, which disfigured her. She had been under the care of several physicians, but had been repeatedly discouraged because she seemed to gain no improvement by treatment. I told the father that I would make no promises, but I thought I could help her, providing she would be under my care for at least three months, and would do just as she was told. For the purpose of holding both patient and doctor to faithful work (for it may be said parenthetically that doctors being human are likely to be discouraged if good results are not seen quickly), I proposed the following plan to the father, which was readily agreed to, and was put in writing, one copy being kept by the father, the other by myself:

(a) I to treat the patient for three consecutive months from date of writing, either at my office or at her home, seeing her as many times as I thought best, but not less than three times each week.

(b) To send my bills in on the first day of each month following the month of treatment.

(c) The patient to call at my office for treatment whenever asked to, and to *keep all* appointments, and to follow out the attending physician's directions and no other advice or direction.

(d) The directions to be in writing, and full and explicit.

(e) Bills to be paid promptly on receipt thereof.

(f) If any of the parties interested in the contract fail to do as agreed, the others may withdraw.

This simple agreement answered nicely. The doctor felt reasonably sure of three months' treatment of his patient and of receiving his money promptly. The patient had the confidence that a contract gives, and came promptly and as agreed upon,

even when she felt that the forthcoming treatment would be severe. The father, who paid the bills, felt, as he expressed himself, "I am satisfied, for I know something about where I am. It's business." The case progressed nicely, to the satisfaction of all concerned, and though after the three months had expired the family were out of the city for several months and treatment had to be discontinued, and a cure in the ordinary sense had not been made, still all concerned were convinced that with the agreement much more had been accomplished than could have been without it.

It will be noticed that in this agreement the physician does not promise a cure, only to do what he believes he can do; neither does he say "no cure no pay," though in some rare instances it may be wise to do so.

In no class of cases has greater benefit resulted than in prolonged gastro-intestinal ailments of children. There are ordinarily so many details necessary as to food, bathing, exercise, and other hygienic measures in the treatment of such ailments, that even the most attentive and careful of mothers or nurses is liable to forget some of them, and has too much pride to ask the doctor to repeat them. The busy doctor rattles off his directions from time to time, feels pleased with himself for his carefulness, but finds, perhaps accidentally, that his orders have not been carried out. The mother or nurse "forgot" what he said; "there were so many things to remember." Even the doctor in the multiplicity of directions he is called upon to give in a busy round of practice finds that he, too, forgets, and is reminded, perhaps, by his little patient that what he says to-day about what he wants done is entirely different and opposed to what he directed yesterday.

It will be said by some that the writing of directions will be a bore for physicians. It need not be, for the physician can furnish himself with blanks having printed headings and sub-heads. After one has become accustomed to filling out these blanks the work will not be irksome, especially when he realizes the value of written directions in the economizing of time, by saving repetition of oral directions, in his having something to refer to in confirmation of the advice he has given, in the hold which in most instances the directions have upon the patient or his friends. Of

course he should be paid for the writing out of these directions.

The directions should be dated, and plainly state who they are written for. Then may follow the headings: Food, air, clothing, exercise, bathing, medicine. If several medicines are to be used it is well to number the prescriptions, No. 1, 2, etc., putting not only when and how each is to be used on the vial or other vehicle containing the medicine, but also in the written directions. One hears complaint from time to time from people, that doctors don't plainly state just how medicines should be used, but say, "Use as directed." But, as one lady said: "I have so many bottles of medicine with, 'Use as directed' on that I don't know what to do half the time when I go to my medicine-closet."

If with written directions from the doctor there can be frequent but concisely written reports *for* the doctor, as to the food taken, its effect, the amount of sleep, the condition of the urine, the number and character of the passages, etc., there will be more precision in the practice of medicine, more satisfaction, and better pay. For these reports printed blanks may be prepared, as printed documents inspire more respect than those entirely written.

In my experience, written or printed directions are usually looked upon by those using them as something tangible—something that will help the memory and prevent perplexity. We, as physicians, are apt to believe that most persons know how to prepare barley-water and other things which seem commonplace enough to us, but many of us have been surprised to find how few people really do know, and it is not always easy to refer such persons to a reliable and accessible book. How much better it would be to have at hand some printed slips giving such information!—*Arch. of Pediatrics*, Sept., 1887.

Phillips (S.) on Pulsating Aorta.—Pulsating aorta is very frequently accompanied by epigastric and umbilical pain, often radiating widely through the abdomen, and in some cases there may be persistent pain in the back. The pain is apt to have exacerbations, and seems greatest when the throbbing is most violent; it is sometimes uninfluenced, in other cases it is increased, by the recumbent position. There may or may not be increase of pain on taking food, but usually the pain is worst at night.

Besides the acute pain, most observers are agreed as to the extreme distress and discomfort which accompany the pulsation, the patient becoming restless, sleepless, and despondent, and very anxious for relief; these symptoms all pass away with the disappearance of the pulsation.

In some cases there are more or less frequent gastro-intestinal hemorrhages.

Another symptom met with in some cases of pulsating aorta is the *presence of a tumor in the abdomen*; and, indeed, the patient sometimes calls attention to this as his chief symptom. The tumor is doughy or elastic to the feel, and may be tympanitic on percussion if the patient can be induced to relax the tension of his abdominal muscles. The tumor is evidently a part of the intestine distended with gases, and forming a local swelling either from a temporary paralysis of its own muscular wall, or from a spasmodic contraction of the lengths of intestine above and below it.

Dryness of the mouth, tongue, and palate, and contraction or dilatation of the pupils often co-exist with this disease. It is most commonly met with in men beyond middle life, and is attributable in some cases to strain. Post-mortem examinations have revealed no lesions of the aorta.

The diagnosis between the pulsating aorta and abdominal aneurism cannot be made without care. In both there may be a violent impulse, with systolic *bruit* and thrill, and in both, as I have pointed out, there may be gastro-intestinal hemorrhages, and a tumor felt in the abdomen by the surgeon, and pain in the abdomen and back by the patient. The chief point on which the diagnosis must rest is the different character of the pulsation in the two cases; in aneurism the pulsation is expansile, in pulsating aorta it is a violent jerking, and its direction is directly forwards (though if the vessel is very tortuous this may not be evident at once); it will, I think, in pulsating aorta, be almost always possible, by gradual, equable, firm pressure on the abdomen, to feel the vessel, and to ascertain that there is no aneurismal tumor connected with it.

In some cases extreme tenderness over the aorta may prevent this, and then the diagnosis must depend on the course of the disease. In simple, pulsating aorta the pulsation is very apt to intermit at times, in aneurism much less so; and aneurisms tend gradually to enlarge, and the symp-

toms become more severe, while the simple pulsation may continue for months or years without further development.

In the treatment of pulsating aorta I have no specific remedy to recommend. If any mechanical cause be present, such as accumulation of fæces, this must be removed where possible. Where impossible, as in the case of tumors, all that can be done is to relieve the pain by sedatives. In some cases, when due to gastric or intestinal irritation, it soon passes off when this is removed by ordinary remedies. I have found it relieved for a time by bismuth and opium, but the opium requires to be pressed. Bromide of potassium, as Dr. Walshe observes, may control the pulsation; but it, like the opium, is often required in somewhat large doses. Iodide of potassium with alkalies certainly gave relief in one case; but here there were evidences of syphilis in the patient. In cases where it is persistent and no cause can be found for it in men of advanced life, the gouty diathesis should be borne in mind.—*Br. Med. Jour.*, Oct. 8, 1887.

Jones (J. D.) on a Case of Acute Lobar Pneumonia with Protracted First Stage.—Benjamin J., aged twenty-two, of good constitution, but a hard drinker, was in his usual health up to September 28, 1887, when he had a severe chill. He was so ill that he kept his bed, but did not call a doctor till October 2d. He was then complaining of headache, a slight cough, and vomiting. His pulse was 120; temperature, 104.5°; respiration normal. Pneumonia was suspected, but physical examination of the lungs revealed nothing abnormal. His bowels were loose, owing to some "opening medicine" he had taken. Gurgling was obtained in the right ileo-cæcal region—a sign found in looseness of the bowels from any cause. He was given some antipyrine to reduce his temperature.

October 3d. A.M. Pulse, 102; temperature, 102.5°; respiration normal. Headache, cough, and persistent vomiting. P.M. Temperature, 103.5°; other symptoms the same as in the morning. As six days had now elapsed since the chill, and physical examination of the chest revealed nothing abnormal, and owing to the prevalence of typhoid fever in the city, the case was reported to the board of health as one of that disease.

October 4th. He was delirious last night, and to-day he complained of severe stitch

in his right side. Severe epistaxis. A.M. Pulse, 102; temperature, 102°; respiration, 32. P.M. Pulse, 104; temperature, 103.75°; respiration, 32. A crepitant râle was heard over the lower lobe of the right lung posteriorly.

October 5th. A.M. Pulse, 108; temperature, 103.5°; respiration, 48. The physical signs of consolidation were heard over the posterior aspect of the right lung.

October 6th. The whole of the right lung is now consolidated. It will not be necessary to give the details of pulse, temperature, respiration, etc., the case pursuing the usual course of a severe pneumonia with active delirium throughout, and ending fatally October 14th, ten days after the crepitant râle was heard, and seventeen days after the chill.—*Boston Med. and Surg. Jour.*, Nov. 10, 1887.

Baron (B. J.) on Hoarseness and Loss of Voice.—In the term "hoarseness" the author includes alterations in *pitch* as well as in *clearness*. The *speaking* voice may be unchanged, while there exists a marked interference with the *power* and range of the *singing* voice, indicative, possibly, of grave disease. The causes are various, and in 100 cases observed, were found to be divided among the following in order of frequency:

1. Chronic laryngitis.
2. Hysteria.
3. Phthisis laryngea.
4. Laryngeal anæmia, especially in phthisis.
5. Acute laryngitis.
6. Laryngeal syphilis.
7. Growths in the larynx.
8. Aneurism.
9. Œdema of the larynx.

In treatment of the first-named condition the author urges the importance of rest and avoidance of irritants of every kind. For local application, chloride of zinc, gr. xv.—xxx. to glycerine $\frac{3}{4}$ i., applied daily for a week or ten days, and then at gradually lengthening intervals, has been found most serviceable. For genuine hysterical aphonia endo-laryngeal galvanism is recommended. For the dysphagia of laryngeal phthisis the application of cocaine in 10- to 20-per-cent. solution in glycerine of borax has been found useful. Insufflations of oxychloride of bismuth and morphia, and inhalations of the compound tincture of benzoin and oil of eucalyptus, are also soothing. To keep the ulcers

clean, inhalations of creasote and terebene, and insufflations of iodoform, are preferred. No good result has been obtained with 20-per-cent. solution of menthol in olive oil as an application. Lactic acid, from 10 to 70 per cent., has seemed to clean the ulcers and promote healing and cicatrization. Scarification seems to offer no advantage. The usual treatment is advised for acute laryngitis. Two cases of laryngeal neoplasm, one sessile and the other pedunculated, were much benefited by applications of the chloride-of-zinc solution. Improvement in the voice of a patient with a large innominate aneurism occurred with shrinkage of the sac, under treatment, and removal of pressure.—*Bristol Medico-Chir. Jour.*, Sept., 1886. C. H. K.

Downie (J. W.) on Dryness of the Throat from Excessive Tea-Drinking.—Some three years ago I pointed out to some of the students a form of dry pharyngitis occurring in badly fed anæmic women, which I then in great part ascribed to the excessive use of cheap, and therefore inferior, tea. On inquiry it was found that those women had tea with almost every morsel of food of which they partook, and the tea, of a rank order, was not simply infused, but literally *stewed*.

For a time, in addition to proscribing the use of tea (recommending the substitution of cocoa or milk), I advised the liberal use of farinaceous food with milk, and prescribed a chalybeate tonic, under which the patients rapidly recovered. After a time I prescribed no medicine, directing the change of diet indicated alone, with the same beneficial results; but patients are never thoroughly satisfied unless they get a bottle, and as preparations of iron materially assist in the cure of the accompanying anæmia, I have returned to my former prescription. Those patients when asked if they use much tea confess to it freely, but add that since the throat became so dry they have quite lost taste for it—have “turned against it.”

Now in all such cases I look upon this form of dry pharyngitis, which does not involve the naso-pharynx as in *pharyngitis sicca*, as in great measure due to the gastric derangement—the dyspepsia—induced by the constant use of stewed tea shortly before, with, or immediately after meals, as well as to the local effect on the pharynx itself of this frequently-applied astringent and irritant lotion. And just as we forbid

the use of tobacco in certain inflammatory conditions of the mouth and fauces, so the total abstinence from tea should in all such cases be rigorously enjoined.—*Practitioner*, Oct., 1887. C. H. K.

Ferret (P.) on Tubercular Meningitis Following a Simple Dilatation of the Lachrymal Duct in a Scrofulous Subject.—A woman of thirty-eight, scrofulous and afflicted from childhood with an intense ozæna, consulted her physician for a dacryocystitis. An operation was performed, under chloroform at the request of the patient, and a canula was left in the enlarged duct. The patient vomited some when coming out from the anæsthesia, but otherwise had no bad symptoms. Within a week symptoms of meningitis set in, and the patient, getting rapidly worse, died within two weeks after the operation.—*Le Prog. Méd.*, Oct. 8, 1887.

Johnson (J. B.) on the Fluid Extract of Ergot for Incontinence of Urine in Children.—I have been using for many years the fluid extract of ergot in the treatment of incontinence of urine in infants and children; and I almost regard it as a specific for the disease. I prefer to give it simply, and to treat separately any condition of the patients that may require therapeutical aid to correct those states of physical debility which either predispose to incontinence of urine or aggravate its presence. I give to an infant from one to three years old, 5 to 10 drops; and to a patient from three to ten years, 10 to 20 drops every three hours. Few children object to its taste, and it should be continued uninterruptedly for two or three weeks, and resumed if the disease should return, in which case the doses ought to be gradually increased.—*Med. and Surg. Reporter*, Oct. 22, 1887.

Ady (A.) on Persistent Priapism.—I had a patient, thirty-one years old, die a few days ago from enlargement of the spleen. It was enormously hypertrophied, resting upon the pelvis and filling and distending almost the whole abdomen. The patient continued to go about town to within ten hours of his death, which was due to coma. The singular circumstance connected with the case was persistent and painful priapism for the last week of his life. After death, and up to the time of his burial, there was no relaxation of this condition. The corpus spongiosum and glans was seemingly filled by a solid coagulum. The

patient's disease commenced a year ago, and painful erections often troubled him for a few hours at a time, but did not become continuous until the time spoken of.—*Med. and Surg. Reporter*, Oct. 22, 1887.

Verrier on Pruritus Vulvæ Consecutive to Leucorrhœa.—The pruritus caused by leucorrhœa is very rebellious. According to some, after emollient lotions, a weak infusion of tobacco, a decoction of lupulin, a solution of borate of soda (3.-50.), or one of sublimate (1.-1000), or one of phenic acid (1.-500.) suffices.

The author employs the following solution :

Acetate of morphine	4. parts.
Liquid phenic acid	5. "
Dilute hydrocyanic acid	30. "
Glycerine	100. "
Water	1,200. "

After having washed the parts with the above solution, dry them and apply powdered starch. If the pruritus does not yield to this treatment, a tampon of lint saturated with the solution should be held to the parts by means of a compress and bandage.—*Rev. Méd.-Chir. des Maladies des Femmes*, Sept., 1887.

Cowgill (W. M.) on Controlling Epistaxis.—The method used was douching the nose with a fountain syringe, using the water as hot as it could be borne, passing it up the bleeding nostril and allowing it to return through the other, the patient inclining the head forward and breathing through his mouth. The stream of hot water was kept up until it came from the nose perfectly clear.—*Am. Pract. and News*, Oct. 29, 1887.

Marshall (C. F.) on the Structure of Muscle.—In all muscles which have to perform rapid and frequent movements a certain portion of the muscle is differentiated to perform the function of contraction, and this portion takes on the form of a very regular and highly specialized intracellular network. This network, by its regular arrangement, gives rise to certain optical effects, which cause the peculiar appearances of striped muscle. The contraction of the striped muscle fibre is probably caused by the active contraction of the longitudinal fibrils of the intracellular network; the transverse networks appear to be passively elastic, and by their elastic rebound cause the muscle to rapidly resume its relaxed condition when the longitudinal fibrils have ceased to contract; they are

possibly also paths for the nervous impulse. In some cases where the muscle has hitherto been described as striped but gives no appearance of the network on treatment with the gold and other methods, the apparent striation is due to optical effects caused by a corrugated outline in the fibre. In muscles which do not perform rapid movements, but whose contraction is comparatively slow and peristaltic in nature, this peculiar network is not developed. In most if not all of the invertebrate unstriped muscle there does not appear to be an intracellular network in any form, but in the vertebrate unstriped muscle a network is present in the form of longitudinal fibrils only. This possibly represents a form of network intermediate between the typical irregular intracellular network of other cells and the highly modified network of striped muscle. The cardiac muscle cells contain a network similar to that of ordinary striped muscle.—*Lancet*, Nov. 5, 1887.

Helmuth (W. T.) on Acute Dilatation of the Stomach Following Laparotomy.¹—The operation was supravaginal hysterectomy for myo-fibroma. Every thing went well for the first day, when gradual distention of the abdomen took place, and the patient began to vomit or rather gulp up mouthfuls of fluid. The temperature was not high, probably 102°, and I believed she was suffering from peritonitis. There was a short respite between these attacks, during which she would doze, only to be aroused by fresh regurgitation, the fluid toward the last being brownish, flaky, and having the peculiar odor of the ingesta in gastritis. She died upon the fifth day from asthenia, and upon making the usual post-mortem incision in the linea alba, there protruded immediately what at first I thought must have been an enormously distended colon. Further examination showed that it was the stomach, occupying the whole abdominal cavity, and holding by actual measurement, after its removal, thirteen pints of fluid. There was not a trace of any diseased action in any other of the abdominal organs, except the head of the duodenum, which was also slightly expanded.—*Am. Jour. Obstetrics*, etc., Nov., 1887.

Allbutt (T. C.) on Simple Dilatation of the Stomach or Gastroectasis.—According to the author, gastroecta-

¹ See MEDICAL ANALECTIC, Nov., 1887, p. 514.

sis, which, in its fully established form, is a prominent and unmistakable malady, enters in less degree into many modes of dyspepsia, debility, and tissue failures, and claims in its degree due recognition and treatment. In most cases, gastric dilatation of the simple variety is more often due to failure of resistance than to excessive pressure within. He narrates the instance of a brother and sister who developed gastroectasis, the one after acute rheumatism, and the other after acute rheumatism and during acute tuberculosis.

In all fevers, whether adynamic or not, this condition may, and often does occur. In phthisis it is far more common than is generally supposed.

In infants and young children dilatation of the stomach is constantly overlooked. Abnormal decomposition of food readily sets in. The epigastrium protrudes and tightens, the stools grow costive, pale, and offensive, the child becomes fretful, rejects sour mucus and altered food, and its flesh falls rapidly. By palpation and percussion a dilated stomach is often found to be present, not as a varying and transitory phenomenon, but as an enduring pathological change, less difficult to cure than in older persons, for children soon grow out of their maladies, but bad enough to keep the child back for months.

Gastric catarrh, the tendency of which is to weaken parietal resistance, is often a cause. Less easy to explain, though not of the obscurest, are such causes as failing absorption, chronic venous congestion of the stomach, failing digestive secretions, and the like.

It is said that the stomach may be palsied, or lose much of its nervous life or stimulus, as other limbs may, either by its own isolated misfortune, or sharing in a more general stroke. The author refers to a very large class of cases in which general neurasthenia, or nervous weakness or distress springing from the region of the digestive organs, and thence invading and depressing the whole being, is associated with marked gastroectasis, but whether the nerve lesion or the lesion of the stomach be primary is a question. There is a frequent connection between gastroectasis and a large and fairly constant group of nervous symptoms and sensations, a group variously called hypochondriasis or hysteria, according to its conditions. That under some strange gusts of nervous temper the

stomach of a woman, or even of some men, may become distended like a balloon, and yet collapse again, suffering no permanent injury, is amazing. In these, pyloric incontinence probably prevents the permanent injury. The dilated stomach of a so-called hipped man is, however, a graver matter, for in him the organ is often found to be permanently enlarged, and its reduction a matter of difficulty, or even impossibility. In some of these cases, no doubt, the stomach lesion came first, and the general misery followed, but in others one strongly suspects the stomach has yielded because of some nervous weakness. The distressing epigastric sensation in these cases, the tenderness there, and the character of other symptoms lead to the suspicion of an affection of the great abdominal nervous ganglia.

Gastroectasis may be induced by excessive pressure upon the minor surfaces of the organ, even in cases where the pyloric exit is intact. Prolonged or immoderate irritation of the cavity, as by the habits of the common glutton, produces a certain and even considerable amplitude of that organ. That which brings gastroectasis to its graver and irremediable degrees is a dietary at once bulky and coarse or innutritious.

The hasty ingestion of bulky, indigestible food, with at the same time copious libations of tea, seems to cause the disease in some cases, aggravated flatulent dyspepsia apparently helping on the morbid process. The condition has been traced in more than one case to the abuse of aerated waters. Dilatation of the stomach is much less common in women, perhaps because they eat less or eat more regularly, but in them exhausting discharges are a potent cause of the malady, and in them, as in the male sex also, neglected hemorrhoidal losses will have this effect.

In all cases of dyspeptic troubles the stomach should be carefully mapped out.

A dilated stomach may be suspected if a wearing aching pain abide in the pit of the stomach, and if there be foul or acid eructations. Vomiting is not invariable; some people have not the knack of vomiting; in others the walls of the stomach may be too flaccid to aid in rejecting its contents. In others, where the stomach is hypertrophied in mucous and muscular coats, as in gorging eaters, absorption and peristalsis may be fairly good. In such

cases physical signs must be sought for. In better marked cases the vomiting is often thus characteristic that the stomach rejects its generally voluminous contents, as a pump ejects water; the refuse comes forth in a rushing stream, often without any nausea whatever, and often at tidal intervals, which may be very long, may be as long as two days, but generally are less than that. In such cases we always see a drawn face, a worn and pained expression, and an emaciating body. The patients complain of constant weary pain about the waist, relieved by the vomiting. The vomit may sometimes be mere catarrhal matter, phlegm and water, and is not then pathognomonic, or it is a turbid, sour liquid containing remnants of half-dissolved food in a state of active fermentation. It is usually dark in color, and swarms with sarcinous and other low forms of life. Stir up the materials of a day's meals, add dirty water and catarrhal slime to it, set it aside at a temperature of 100° for a few hours, and thereafter froth it up with a stick, and you will have the foul vomit of gastroectasis. The stomach, like an incompetent bladder, never really empties itself, however vigorous the vomiting, and the fetid remnant carries forward the process of decomposition to all that is swallowed.

The physical signs of this state when so complete are clear enough. The emaciated abdominal wall, the sac beneath it quite perceptible to the hand lightly stroked over the surface and often to the eye, peristalsis also visible, perhaps if the muscular coat be hypertrophied (this more commonly in pyloric destruction) splashing and percussion areas,—all agree in declaring the diagnosis.

By percussion, the upper line of the stomach, in acute or early cases, may reach the axilla before the whole organ is dragged downward. When the lower border of the stomach can be mapped out below the umbilicus, a dilated organ may be diagnosed. Leube's sound is sometimes of great use in determining the size of the organ, either by feeling its tip through the abdominal wall, or by measuring the length inserted beyond the teeth.

A common increase is to about four times the normal cubic contents, *i. e.*, an increase up to about six quarts.

The indications in treating the condition are :

1. To cleanse the stomach.
2. To prevent its distention by physical or chemical means.

3. To combat the prevalent constipation. The constipation is best overcome by portal purgatives, laxative salines.

As the stomach recovers tone the costiveness becomes less obstinate, as the bowels then receive more reflex stimulation.

The dietary must be strictly limited to such foods as shall not by bulk or by decomposition distend the stomach. Meals must be small if frequent, and must consist of flesh, fish, or fowl, and the more digestible and finely divided fats. Dr. Fenwick recommends cod-liver oil. Farinaceous foods cannot be wholly forbidden, but, owing to their tendency to gaseous decomposition, must be greatly restricted. The dietary should be as dry as possible. As the peptic glands are often reduced or obliterated, artificial digestive means should not be forgotten. The only known means of cleansing the gastric receptacle is Kussmaul's system of washing out. To deny the catheter to the palsied stomach seems to me as unreasonable, and in practice is as great a blunder, as to deny it to the palsied bladder.

Ebstein uses a No. 8-10 Nélaton's catheter and warm water, with a little benzoate of magnesium, and relieves catarrh and wasting dyspepsia, etc.

In purely nervous dyspepsia, so called, the stomach between meals contains no remnants of food, no fungi, no excess of hydrochloric acid, and no mucus, but from this starting-point one may begin to note all degrees of catarrh and of ectasis. Plain warm water is all that is required for the ablution, though a little borax may be added to the wash. In the beginning of treatment, when the contents of the stomach are bulky and lumpy, it is well to use the stomach-pump. With a large lateral opening in the lute, and careful exhaustion, there is practically no likelihood of harm. For subsequent treatment, when the stomach contents are cleaner and less bulky, a syphon is simpler, and, moreover, if fitted with a reservoir, can be used by the patient himself. The cistern must be placed just above the level of the head and attached to the flow pipe, and an exit pipe must be carried to a pail on the floor. By pinching the flow pipe the patient can easily regulate the flow. Other remedial means, such as the use of drugs, and of nutrient enemata,

need not be discussed. Electricity has greatly disappointed the author's expectations in whatever mode or however applied. A stomach pad, supported by a bandage, should always be worn, and Leube orders his patients to lie down as much as possible, and that on the right side only.—*Med. Press*, Oct. 26, 1887.

SURGERY.

ABSTRACTS AND SELECTIONS BY GEORGE B. PHELPS, M.D.

Southam (F. A.) on the Radical Cure of Hydrocele.—The radical cure of hydrocele at the present day is usually carried out in one of the following ways, namely: by injection, by antiseptic incision (Volkman's operation), or by excision of the tunica vaginalis.

The last of the three methods—namely, that by excision of the parietal portion of the tunica vaginalis, first introduced by von Bergmann, and described by Brannan¹—is a plan of treatment which, so far as I am aware, has not hitherto been much adopted in this country. The operation is a simple one, and in four cases in which I have adopted it has been attended by the most satisfactory results. Bull, of New York,² who has employed the same method in three cases, regards it as the only truly radical operation,³ and speaks very highly of it. It may be performed in the following manner, which, except in a few minor details, is identical with that of von Bergmann. The cavity of the tunica vaginalis is laid freely open by a vertical incision between two and three inches in length, made over the most prominent part of the swelling; the fluid will at once escape, and as it does so it is useful to secure the margins of the opening in the tunica vaginalis on each side with a pair of catch forceps, otherwise there may be a little trouble in distinguishing them after the evacuation of the fluid, and the walls of the sac have collapsed and fallen together. The tunica vaginalis is then dissected out on either side up to the point where it is reflected upon the epididymis, testis, and cord, by putting it on the stretch and separating it from its connections with the surrounding parts by means of the finger, assisted by a scalpel or pair of scissors.

It is astonishing how little hemorrhage accompanies the proceeding if the finger is chiefly used. In my last case not a single vessel had to be secured. The whole of the tunica vaginalis is then removed, with the exception of the portion covering the epididymis, testis, and cord, by cutting through it close to those structures with scissors. All bleeding points having been secured, a drainage tube is brought out through the upper part of the wound and a counter opening made at the most dependent point of the scrotum. The interior of the wound, which will have contracted very considerably, is dusted over with iodoform, closed with a few sutures, and dressed with iodoform gauze and a wood-wool pad, care being taken that the scrotum is afterwards kept in an elevated position. Healing rapidly takes place, the slight swelling which follows the operation soon subsides, and the patient will usually be able to leave his bed and get about in the course of a week or ten days. Though applicable to all cases of hydrocele, this method is especially valuable in those of long standing, where the tunica vaginalis has become much thickened and of dense consistence. As compared with the other plans of radical cure, the excision method has this advantage—namely, that it is almost practically impossible for a recurrence of the hydrocele to take place.

In the method by injection with iodine or carbolic acid (the latter fluid being now generally used), a recurrence takes place in a certain proportion of cases. Of three cases which I have recently treated in this way, the hydrocele returned in one. It may be alleged against the excision method, as compared with the injection treatment, that it is more severe, and necessitates confinement to bed; but even in cases of injection the inflammatory symptoms are often so marked that the patient is unable to get about for several days.

This method I think superior to Volkman's plan, considering it more certain, and the time of healing in many cases is less in this operation.—*The Lancet*, Sept. 10, 1887.

Thomas (J. D.) on a Case in Which Alarming Symptoms of Collapse Followed Immediately upon Aspiratory Puncture of an Hydatid of the Spleen.—The patient was a married, non-hysterical

¹ *Berliner klin. Woch.*, April 6, 1885, p. 209.

² *New York Medical Journal*, March 13, 1886.

woman aged thirty-seven. The diagnosis of hydatid of the spleen was made, and it was determined that an exploratory puncture should be made, partly to establish the diagnosis, partly to ascertain at what depth in the spleen the cyst lay. If it were ascertained by the exploratory puncture that no great thickness of spleen intervened between the surface and the cyst, it was my intention to operate by incision. Accordingly, I performed an aspiratory puncture with a needle of fine calibre. The needle was a new one, and had been dipped in 5 per cent. carbolic lotion, all fluid being removed by drawing the needle between the finger and thumb immediately before its insertion. The needle was passed slowly and vertically into the most prominent part of the tumor, in the left nipple line one half inch below the costal margin, but when its open end was well below the skin the vacuum was turned on with the object of ascertaining exactly at what depth the cyst lay. At first a small amount of blood passed, but at the depth of one and a half inches clear fluid flowed freely. As it was not my wish to empty the cyst, the needle was withdrawn after about three ounces of fluid had been removed.

The patient complained but little of pain at the time, but within five minutes I noticed her face suddenly flush, and she commenced to scratch her face, neck, and arms. Over the itching parts were seen erythematous patches, but no distinct wheals of urticaria. Besides the itching, she complained of abdominal pain. In the course of a few minutes her face became dusky, her hands and feet cold, and the radial pulse became imperceptible. Consciousness appeared to be lost, and her general aspect was exactly that of a person in the "algide" stage of cholera. She was to all appearance moribund, and continued so for over three quarters of an hour. No pulse could be felt at the wrist, the heart-beat and sound was scarcely perceptible, the respiration was hurried and labored. Hypodermic injections of ether were introduced at intervals in the right buttock, into both upper limbs, and into the left pectoral muscle, in each case about thirty minims being used. In from 45 to 60 minutes after the onset of the symptoms, and a few minutes after the use of the ether injections, the patient rallied somewhat and spoke. She complained of abdominal pain, and expressed a desire to go to stool. Of course

this could not be permitted in her still almost pulseless condition, but she at once passed two rather liquid motions into cloths arranged for the purpose in the bed. The motions were semi-fluid at first, and then watery, and one of them contained a doubtful trace of blood. Copious watery vomiting also occurred, and the vomiting and diarrhoea were the earliest phenomena of reaction.

The radial pulse was first felt two hours and a half after the operation. Within a few hours patient became very thirsty, vomited, and had several movements of the bowels.

On the fifth day patient sat up, and on the ninth day went out of doors.

Other similar cases are referred to in the article.—*Australasian Med. Gazette*, June, 1887.

Howe (W. E.) on Dislocation of the Scapula.—The patient, a sailor, slipped on a piece of orange-peel and fell, striking the back of his left shoulder against the curbstone. When I saw him, half an hour after the accident, he was sitting stripped to the waist, and leaning forward so as to support the left elbow on the knee. The anterior axillary fold was lower on the left side than on the right, and the girth round the shoulder through the axilla was also greater on this side than on the other by an inch. The left clavicle was the same length as the right, and, like the left acromion, was smooth in outline and continuous with itself all round; however, between the clavicle and acromion was a deep groove in which the finger could be laid. The scapula had been displaced downwards, outwards, and forwards, the tip of the coracoid being an inch and a quarter below and a little to the inner side of the outer end of the clavicle. On pressing the clavicle down and the shoulder upwards and backwards, the pain (felt along the insertion of the trapezius chiefly) was relieved, and the normal appearance of the shoulder was restored. To retain the parts in position, the outer end of the clavicle was fixed by a piece of strapping (4 inches by 15 inches) passed over it, another strap, folded round the middle third of the arm and drawn tightly across the back, steadied the arm and shoulder, while the elbow was brought forward and pressed upward by a flannel roller, passing round the body and over the right shoulder. The patient was then laid on his back in bed. On July 9th the strapping

was reapplied; and on the 17th he was allowed to get up. The strapping was removed on the 22d (three weeks after the accident), and he was discharged to duty, well, on the 24th.

Seen again on August 21, 1887, fourteen months after the accident, he declared that the arm was as strong as ever, and that it gave him no inconvenience. The outer end of the clavicle is somewhat thickened; but the relations of the clavicle to the coracoid, acromion, and scapula, generally, are quite normal, and are so maintained during movements, which are all perfectly performed.

The primary treatment was Sayre's for fractured clavicle; but I believe that the fortnight's rest in bed had nearly as much to do with the successful result.—*British Med. Jour.*, Oct. 8, 1887.

Whitehead (W. R.) on Dislocation of Both Condyles of the Lower Jaw; Reduction after Sixty-two Days.—The patient was a woman aged forty-eight, who was given gas by a dentist for the insertion of a plate of false teeth.

The jaw was then dislocated, but this fact was not known to patient or dentist, and no attempt was made at reduction until seen by the writer two months later.

Ether was administered, and after much manipulation and with the use of much force complete reduction took place, and the patient made a good recovery.—*Med. Standard*, Oct., 1887.

Littlewood (H.) on a Method of Detecting and Removing Needles Embedded in the Tissues.—1. The part supposed to contain the needle is thoroughly rubbed over with an electro-magnet, so as to magnetize the metal if present. 2. A delicately balanced magnetic needle is held over the part. If the needle is present, its position can be ascertained by the attraction or repulsion of the poles of the magnetic needle. 3. Having ascertained the presence of a needle (*e. g.*, in the hand), the part is rendered bloodless, and a grain or more of cocaine is injected hypodermically. 4. An incision is made over the ascertained position of the needle. 5. The electro-magnet is then inserted into the wound, and with it the needle is felt for. Sometimes it will be found and removed quite easily, at others great difficulty will be experienced, taking as long as one half or three quarters of an hour. This may be due to the fact that its position has not been accurately ascertained; it may be lying

across the incision, or it may be so firmly embedded in the tissues that the electro-magnet is not able to withdraw it. If this occurs the incision must be enlarged, and the edges held apart with some non-magnetic retractors; using the electro-magnet as a guide, the needle may be seen and removed with forceps. If the needle is firmly fixed, the following plan has been adopted: by placing the positive pole of a galvanic battery on the surface of the body and the negative pole in direct contact with the needle, this becomes loosened by electrolysis and can then be easily removed by the electro-magnet. This latter method has been found useful in two cases for the removal of sewing-machine needles that had transixed the end of the finger, and were so firmly fixed as not to be removable by forceps. The electrolytic action loosened the needles so that they could be removed quite easily.

I have now removed six needles from the hand and a piece of steel embedded in the foot. In none of the cases could I feel the piece of metal or be sure of its presence without the aid of the method above described. As it requires some expensive apparatus, and sometimes takes a long time, I am afraid this method will not become general; but it is well worth the time and trouble spent if in the end one is successful; as patients really suffer a good deal of pain and anxiety if these foreign bodies are allowed to remain embedded in the tissues.—*The Lancet*, Aug. 27, 1887.

Mixter (S. J.) on a Case of Malignant Tumor of the Breast.—In the *Boston Medical and Surgical Journal* for October 13, 1887, the writer reports a case of extirpation of the breast and axillary contents for cancer, and calls attention to the following most valuable and important points:

"In speaking of this operation in general, I wish to lay special stress on the necessity of removing a large amount of surrounding tissue with the gland, making a thorough and systematic dissection of the axilla, in every case, *whether the glands are enlarged or not*, and leaving no tissue between the two through which run the lymphatic vessels. To do this, the fascia covering the pectoralis major and the part of the minor exposed, should be dissected off with the tumor. All the contents of the axilla should be removed except the axillary vessels (which should be first exposed), brachial plexus, and subscapular nerves.

These last, which are given off from the posterior cord of the plexus, should always be saved, if possible, as Kuster has shown, in a late article, that the varying amount of disability in the use of the arm, seen after these nerves have been sacrificed, is avoided when they are left. They supply the subscapularis, teres major, and latissimus dorsi muscles, and can always be readily found during the dissection. If they are divided or removed, paralysis of these muscles follows, and, as a consequence of the paralysis, a growth of connective tissue takes place in the substance of the muscle, making it much less elastic than it normally is. The subscapular vessels may generally be saved.

"The following are one or two practical points in regard to the incision, and the method of sewing up the wound. The mammary incision should be continued along the border of the pectoralis major; in other words, above the upper boundary of the axilla, and the skin should then be dissected downward and backward. By doing this, the line of suture comes well forward in the axilla.

"A quilted suture passed through the axillary skin at a point corresponding to the apex of the axilla, then through the serration of the serratus magnus on the second rib, and out again through the skin, about a quarter of an inch from the point of entrance, the two ends being tied after all the other sutures are applied and just before dressing the wound, almost completely closes the 'dead space' spoken of, and, by carrying the skin so high in the axilla, prevents union of the arm to the side. This I have done in a case operated upon since the one reported, with very satisfactory results. In previous cases I have generally had slight suppuration in this space. A second quilted suture can be passed through the axillary skin and the pectoral muscles, and tied on the front of the chest, if the tension seems too great on the first stitch.

"Drainage, to be successful, must be made by a tube through a buttonhole cut near the anterior border of the scapula.

"I am aware that there is little or nothing new in these suggestions, but it has seemed to me that many surgeons do not appreciate their importance. The old practice of removing the breast alone, in malignant disease of that organ, leaving the axilla if no glands could be felt, and in

case of enlargement removing the glands only, seems to me to be entirely opposed to the ideas of modern surgery. By this method almost no radical cures resulted, and many skilful and judicious surgeons came to look on the operation as almost useless, subjecting the patient to unnecessary suffering and anxiety, without a prospect of corresponding benefit."

Lediard on a Case of Bullet Wound of the Liver; Recovery.—The patient, a constable, was shot through the body, at a short distance, while pursuing some burglars. The bullet entered the right side of the chest, between the seventh and eighth ribs, a little to the outer side of the mammary line. Deep collapse resulted, during which the bullet was extracted from the right loin, just over the last rib, and two inches from the spine. It was believed that the constable was leaning forward to catch a man in front of him when he received his wound. Jaundice supervened, and on the ninth day the extraction wound in the back discharged a large amount of bile-stained fluid, and continued to do so to a less extent for some weeks. Evidence of air in the right pleural cavity to a limited area was also present, and subsequently an empyema formed and discharged freely a large amount of pus through the bronchi. Elevation of temperature lasted more or less for fifty-eight days, but at the end of three months the patient was convalescent, and had made a complete recovery, being still in the Cumberland police. The course of the bullet was, probably, through the convex surface of the liver, the diaphragm being perforated twice, and the lung grazed. The presence of bile was ascertained by chemical tests. The microscope also gave clear evidence of a wound of the liver tissue. The bullet was a large one and weighed $3\frac{1}{2}$ drachms. — *British Med. Jour.*, Oct. 22, 1887.

On the Use of Drainage-Tubes.—In the discussion following a paper on amputation of the thigh for sarcoma, read by Dr. Bell before the Montreal Medico-Chirurgical Society, Dr. Reddick said, in regard to the use of bone-drains, that some years ago he had used them extensively, but had given them up. Recently he had tried them again, but he found that they absorbed too rapidly, and that, although the drain was absorbed and the wound closed up, still there was often a collection of fluid left behind, which had to be let out.

Dr. Shepherd had also, several years ago, used bone-drains, but had abandoned them because of their uncertainty, some absorbing too rapidly and others not at all. He preferred rubber drains. His plan was to change the dressing twenty-four hours after operation, remove and shorten tubes to less than half an inch, and then not make the second dressing for a week or ten days, according as the case progressed. The reason he examines the wound and removes the tube at the end of twenty-four hours, is because the oozing from the wound is greatest during the first day, and also because the tube not infrequently becomes plugged with blood-clots, and this, of course, renders it useless. He had had remarkably good results in his amputations by this method, and mentioned a case of amputation of the thigh performed in a very old man, for senile gangrene, which healed by two dressings in three weeks. Neuber, who introduced bone-drains, now never employs any drain at all, but stuffs the wound with iodoform gauze for two or three days, and then makes use of secondary suture. His results, according to his published cases, were excellent.

Dr. Armstrong inquired whether any of the surgeons had used Levis' solid rubber drains. They consist of a number of pieces of solid rubber rods placed like catgut in the wound, and are better than hollow tubes, as they never get plugged with blood-clot.—*Med. News*, Nov. 12, 1887.

Périer on Excision of a Lumbar Spina Bifida in a Child of Two Months.—A transverse incision was made through the skin and the sac was freely opened. From the interior surface of the sac a large soft band, seemingly a prolongation of the cord, was detached and returned to the spinal canal. The lining membrane of the sac was dissected away and the opening into the lumbar canal closed. The external wound was then simply brought together and stitched. Healing was perfect on the eighth day. On the thirty-fourth day, when the case was reported, no nervous symptoms had appeared.—*Gaz. hebdomadaire*, etc., Oct. 28, 1887.

R. W. A.

Gars on Cancer of the Breast in a Man of Sixty-five.—The patient had always had very well-developed breasts, and stated that for twenty years he had had pricking sensations such as pregnant women have when their breasts begin to

swell. Seventeen months before the operation he fell down stairs and received a severe blow upon the right breast, in which, from that time, he began to have sharp, shooting pain. The region of pain spread and finally involved all that side of the chest and the inner aspect of the right arm.

The nipple was retracted, and underlying it was a small, indurated mass, which was not tender. In the corresponding axilla was a distinctly enlarged gland. The tumor was removed and found to be an epithelioma.—*Four. des Sci. Med. de Lille*, Oct. 28, 1887.

R. W. A.

Bulkley (L. D.) on the Treatment of Felon without Incision.—Unless it is contra-indicated I generally begin the treatment with a mild cathartic, the following being that commonly employed :

℞ Ex. colocynth. comp.
Mass. hydrarg. ʒa gr. x
Pulv. ipecacuan. gr. ii
℥. Div. in pil. No. iv. SIG.—Take two at night and two on the second night after.

A tonic is administered from the first, one containing iron being preferred. The formula of this is as follows, the proportions being somewhat altered to suit individual cases :

℞ Magnesii sulphatis ʒ i
Ferri sulphatis ʒ i
Acidi sulphurici dil. ʒ iv
Syr. zingiberis ʒ i
Aqueæ ad ʒ iv
℥. SIG.—Teaspoonful in water, through a tube, after eating.

In addition to this it is my custom to administer the sulphide of calcium from the beginning to the end of the treatment. I usually give it in the form of $\frac{1}{4}$ grain gelatin-coated pills, one being given every two hours irrespective of food or other medicine. In order to have any good effect from this latter drug, it is essential that it should be fresh and pure. It is well to test the pills by biting them, when the characteristic odor of sulphuretted hydrogen becomes at once noticeable if the article is good.

Alcohol in all forms should be absolutely interdicted, and the malted liquors appear to be also very harmful. The diet should be full and nourishing, but not stimulating. Milk is often given, sometimes in the form of punch and egg-nog between meals. Tea and coffee may be taken in moderation, but unnecessary and indigestible articles should be avoided.

The local treatment of felon consists simply in the constant and very thorough envelopment of the affected part in the

diachylon ointment of Hebra, which, when properly prepared, forms a most agreeable and soothing dressing.

The author does not pretend to abort all cases, as he confesses that in many he gets suppuration and in some necrosis.—*Four. Am. Med. Ass'n*, July 30, 1887.

R. W. A.

Hewlett (W. W.) on Herniotomy under Cocaine Anæsthesia.—A. D.—, aged seventy-nine years and eight months, has long been afflicted with double inguinal hernia; the right developed over forty years ago, the left appeared twenty years after.

He has a weak heart and an intermittent and irregular pulse. He often suffers with œdema of the feet and distressed dyspnœa, for which he is obliged to resort to digitalis.

Owing to an ill-fitting truss, the hernia of the right side frequently descends, but he is generally able to reduce it without assistance. On August 13th it descended into the scrotum, and he was unable to put it back. On the 15th he summoned medical aid, but repeated taxis in various positions of the patient's body, with applications of ice, etc., utterly failed. Stercoraceous vomiting and strangulation of the gut ensued, and it soon became apparent that death must speedily follow unless resort was had to surgical means. The advanced age of the patient and the serious condition of his circulatory system rendered it extremely hazardous to administer ether and chloroform. It was decided therefore to perform the operation with the aid of cocaine.

On August 19th I injected two drachms of a four per cent. solution of cocaine in sixteen different places, seven subcutaneously on either side of a line where the incision was to be made, and two deeper and near the neck of the sac.

After fifteen minutes the operation was performed, under antiseptic precautions, in the usual manner, with the assistance of Dr. E. C. Wendt, of New York; Dr. S. R. Corwith, of Islip; and Dr. A. B. Leggett, of Babylon. The stricture being in the neck of the sac, the latter was opened and the intestine, though deeply congested and purple in color, was returned into the abdominal cavity. The patient was perfectly conscious and a very interested observer during the entire operation. He declared that he felt no pain from the knife, and that we did not hurt him except when the tumor was pushed backward. When he saw the distended intestine rising before his

gaze, he said: "Are you going to tear me all to pieces?"

There was no shock. Free spontaneous dejections occurred during the night. The wound closed by primary union, and his progress toward recovery has been uninterrupted. One week after the operation he sat up on the side of his bed and shaved himself.—*N. Y. Med. Record*, Sept. 24, 1887.

DISEASES OF THE EAR AND EYE

Reid (J.) on Xeroderma Pigmentosa.—A boy, aged 9, suffered from epithelioma of the eyeball at the junction of the cornea, which he had removed a fortnight ago.

The tumor was flat, of a pale, reddish-white color, and extended inwards from about the centre of the cornea to the equator of the eyeball. When first seen, two months ago, the tumor was about the size of a pea, and situated at the corneo-scleral junction. There is also a freckled condition of the skin of the face and hands, with here and there little nodules, depressed in the centre, and with hard, elevated margins. There was not much difficulty in removing the tumor, which was only slightly adherent to the sclerotic, but was firmly incorporated with the superficial layers of the cornea. After hardening in chromic acid, microscopic sections of the tumor showed "pearly nodes," with the columnar arrangement of the epithelium characteristic of ordinary epithelioma. Sections were also made of one of the nodules excised from the skin of the face, and these exhibited hardening of the epithelium, and in the condensed cutaneous tissues hair follicles and glands were embedded, with here and there a typical pearly node.

Regarding this condition of the skin, the parents state that it began when the boy was two years old—little nodules, the centre of each being cast off like "the core of a corn," so as to leave a depression. None of the other members of the family suffer from any affection of the skin.—*Glasgow Med. Jour.*, Oct., 1887.

Rampoldi (R.) on a New Cause of Mydriasis.—One of the less known causes of sympathetic mydriasis is that occurring in certain persons suffering from chronic broncho-alveolar inflammation,

(probably specific). The phenomena are presented at intervals, of a transitory nature, sometimes bi-lateral, more often uni-lateral. This mydriasis is especially noted on a patient passing a night without sleep, tormented by a cough. And when the mydriasis is unilateral I have noticed that the patient complained of pain in the shoulder, and more particularly in the corresponding fossæ of the clavicle and sternum of the same side. This sympathy is due to an irritation of the upper digestive tract, and through this of the upper cervical ganglion of the sympathetic system.—*Recueil d'Ophthalm.*, Paris, March, 1887.

Tiffany (F. B.) on Ametropia.—Having examined 2,040 pupils in the twelve schools of Kansas City and vicinity, found 458 ametropic, or a percentage of 22.4. There were seven nationalities represented among them: the English had the smallest percent. and the Irish the largest percent. of ametropia, Americans being fourth in the size of percentage. Another interesting point was that hazel eyes were found more frequently affected than the other colors, and blue eyes least frequently. The form of ametropia most frequently found was hypermetropia with 9.9 percent., which with spasm of accommodation and latent hypermetropia was increased to 17.8 percent.; while myopia affected 4.6 percent. of the scholars. Another conclusion from the examinations was that the girls suffered more.—*Kansas City Med. Index*, Sept., 1887.

Post (M. H.) on Antipyrine as an Analgesic in Inflammations of the Eye.—In a case of iritis where morphine could not be employed, antipyrine was used with complete success in allaying pain. The pain returned when for sake of proof the medicine was omitted. Dose used was 25 grains at night. Both in specific and non-specific cases it proves serviceable, and it relieves the pain in ulceration of the cornea and slowly progressing panophthalmitis. The method of employment is to use three doses of 20 grains each and 2 hours' interval until the pain is relieved, which requires seldom over the three and many times only one.—*Amer. Jour. Ophthalm.*, St. Louis, Aug., 1887.

Pétrasco on Keratoconus and its Treatment by Myotics and Compression.—The author considers keratoconus, rachitis of the cornea. Mechanical treatment does no good, operative proced-

ures have serious drawbacks. The author finds that the treatment which endangers the organ least of all, consists in the daily use of myotic remedies, and the application of pressure, constant if possible.—*Thèse de Paris, Bull. Gén. de Thérap.*, Sept. 15, 1887.

BOOK NOTICES.

Lessons in Gynecology.—By William Goodell, A.M., M.D., Professor of Clinical Gynecology in the University of Pennsylvania, etc. Third edition, thoroughly revised and greatly enlarged. Philadelphia: D. G. Brinton. 1887.

The third edition of Dr. Goodell's work has made its appearance in a greatly amplified form. The author has made no attempt to produce a complete treatise on the subject, but has made the work correspond with its title—literally lessons in Gynecology. These lessons are eminently practical, dealing with theory as little as possible, and presenting the essential points in diagnosis and treatment in clear, concise, and positive language. Dr. Goodell has drawn his conclusions from a large personal experience, and whatever may be his differences with other authorities, his own opinions are logical deductions from the results of his own work.

On the vexed question of the pathology of pelvic inflammation, the author takes an almost non-committal ground, and treats the subject in the safest manner—from a purely clinical standpoint. As would be inferred from his recently published papers, the author is an ardent advocate of rapid dilatation of the cervix, and is certainly justified in his views by his remarkably good results. With all due respect to his opinions, the criticism may be fairly made that he places a rather dangerous method of treatment in the hands of inexperienced practitioners, whose tendency to abuse the operation will be increased on account of the lightness with which its dangers are treated.

The work is very readable, its colloquial style being only occasionally marred by the use of unfortunate expressions. In a large number of prescriptions, the error of employing the accusative case of *Agua* instead of the genitive, is made. On the whole, the work is exceedingly creditable, and will be read by both student and practitioner with benefit.

J. S. H.

Transactions of the Association of American Physicians.—Vol. ii., 8vo., pp. 254. Phila., Pa.

The present volume contains the proceedings of the second annual session of the association, including the seventeen papers read and the discussion of the same.

Several of the papers have been abstracted and presented to the readers of the *ANALYTIC* already. Among these are, "Sewer-Gas Poisoning," by Henry Hun, M.D. "Atrophy of the Gastric Tubules," by F. P. Kinnicutt, M.D., and "The Frequency with Which Lead is Found in the Urine, etc.," by James J. Putnam, M.D. Bergeon's treatment of phthisis received more than its share of attention by inspiring three papers, while hemorrhagic infarc-

tion formed the text for two. This volume, like the first, is the embodiment of good, sound work, and is a credit to the association publishing it.

PUBLISHERS' NOTES.

CHICAGO, ILL., Sept. 10, 1886.

HENRY RHORER, Esq.,

Treas. Provident Chemical Works, St. Louis, Mo.

Dear Sir.—I received the sample of Crystalline Phosphate a few weeks since, and was well pleased with the results obtained from it, and would not hesitate to recommend it in preference to any preparation of the kind which I have seen or used.

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WM. F. STEUART, M.D.

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